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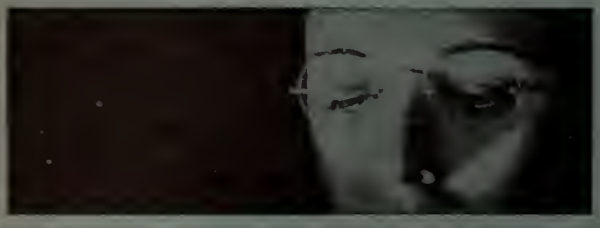
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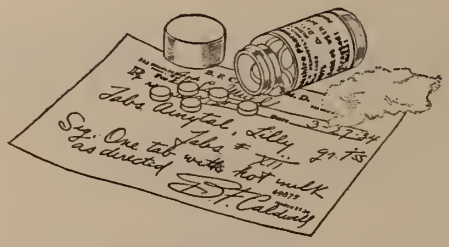
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OPHTHALMOLOGY AND ITS RELATION TO GENERAL MEDICINE AND SURGERY*

NELSON M. BLACK, M.D.,
Miami.

One can but briefly sketch, in the time allotted, the interrelationship between ophthalmology and the special departments into which medicine today is divided. It would take many volumes to go into detail and is far beyond the scope of this paper and the writer's ability.

Outside of the individuals who are directly referred by former patients, practically all the work of the ophthalmologist is that referred by conferes in other branches of medicine.

Why does an individual consult an ophthalmologist? The usual reasons are:

(a) Headaches, localized or general
(b) Visual defects
(c) Discomfort after use of eyes
(d) Inflammation of lids or eyes
(e) Strabismus
(f) Ocular injuries

For these same reasons patients consult their family doctor for information as to what to do in case of eye trouble.

(a) Headaches of ocular origin are, in most instances, due to errors in refraction, usually hyperopia, hyperopic astigmatism, compound hyperopic astigmatism or mixed astigmatism. Headaches are not the rule with myopia or compound myopic astigmatism. Localized headaches may result from imbalance of the extrinsic ocular muscles alone. However, exophoria, hyperphoria, esophoria, or associated phorias in conjunction with errors in refraction are more prone to cause localized headaches.

If the sufferer is in otherwise good physical condition the wearing of lenses, correcting the error in refraction, orthoptic exercises to overcome the muscle imbalance, prisms to correct the same, or operative procedures in extreme cases, usually bring about relief. If the above measures do not mitigate the symptoms a search for causative factors must be made—i.e., a thorough physical examination which may require the aid of the internist, neurologist, rhinologist, roentgenologist, urologist, gynecologist or orthopedist or all of them.

(b) Poor, blurred or failing vision may be due to congenital ocular defects, errors in refraction, external disease of the eye (due to systemic diseases, such as interstitial keratitis in congenital or acquired lues, etc.), beginning lenticular opacities; vitreous opacities, various forms of retinitis, intraocular hemorrhage, chorio-retinitis, optic neuritis and glaucoma. In all such conditions, except errors in refraction and muscle imbalance, search must be made for the etiologic factor.

(c) Discomfort after use of eyes is usually due to errors in refraction or muscle imbalance, causing eye strain. Ocular discomfort after close use is also frequently observed in general asthenia.

(d) Superficially congested or inflamed lids and eyes may be due to eye strain, or to chronic infection of the meibomian glands of the lids or to palpebral and bulbar conjunctival infection.

Refraction and examination of smears and cultures from the ocular secretions will usually determine the cause.

Deep seated inflammation of the eyes with pain, is usually due to profound bacterial infections of the conjunctiva, corneal ulcers, scleritis, iritis, uveitis, and inflammatory glaucoma; also secondary to ocular injuries. In the first two mentioned the etiologic factor must be sought for by the bacteriologist; in the last four, by a thorough physical examination.

(e) Strabismus usually is self-evident and, if not paretic in origin, care of errors in refraction, orthoptic exercises and, as a last resort, surgery will usually bring about correction of the defect. In paretic cases surgery as a rule must be employed. Treatment of squint in children should be instituted immediately the defect is noticed, as glasses and orthoptic exercises, if started early, will frequently obviate operation measures.

(f) Ocular injuries, even if slight, are not infrequently complicated by corneal ulcers, iritis,

*Read before the Sixty-first Annual Meeting of the Florida Medical Association, Jacksonville, April 30, May 1 and 2, 1934.

uveitis and secondary glaucoma, due to local infection or to the influence of foci of infection in the sinuses, teeth, tonsils, alimentary tract, pelvis or prostate; hence the need for cooperation in search for the cause.

The greatest number of patients are naturally referred to the ophthalmologist by the internist, pediatrician, neurologist and otorhinologist. The industrial surgeon, syphilographer, brain surgeon, obstetrician and orthopedist probably follow next in order in the number of cases referred.

The internist, pediatrician, neurologist, brain surgeon and otologist are, as a rule, proficient in the use of the ophthalmoscope and, if no gross fundus pathology is found to account for their patients' symptoms, they are referred to the ophthalmologist for a check-up on errors in refraction, muscle imbalance, slit lamp examination, field of vision and ophthalmoscopy.

The industrial surgeon usually refers all but minor eye injuries for treatment to the eye surgeon.

The syphilographer wishes information as to the appearance of the external eye, condition of extrinsic and intrinsic musculature, the permeability of the refractive media, the fundus findings, the size of the form and color fields and the relative size of the blind spot, before instituting treatment.

The obstetrician, unless expert with the ophthalmoscope, desires information as to the condition of the fundus in cases showing albuminuria to determine if neuroretinitis of pregnancy exists.

In increased intracranial tension and pituitary disturbances the brain surgeon relies to a large extent on the ophthalmoscopic and the perimetric findings in deciding upon operative procedures.

The orthopedist frequently refers patients with wry neck and spinal curvature, etc., to determine if the eyes may not be an etiologic factor in their production.

In turn the vast majority of the cases referred by former patients must be re-referred to practitioners in other branches of medicine for aid in determining and confirming a tentative diagnosis made by the ophthalmologist. These include, and from the writer's observation are of greatest help in such confirmation, in the order named:

1. Internist and Pediatrician
2. Neurologist
3. Otorhinolaryngologist
4. Bacteriologist and Pathologist
5. Syphilographer and Dermatologist
6. Roentgenologist
7. Urologist
8. Gynecologist
9. Brain Surgeon
10. Oral Surgeon
11. Orthopedist
12. General Surgeon.

In case careful correction of errors in refraction and muscle imbalance do not relieve localized or general headaches or there is found pathology in the refractive media or there exist fundus lesions, we go to the internist and pediatrician for help to discover any systemic condition which may account for the continuance of symptoms.

Careful checking of the circulatory and nervous systems, alimentary tract, urinary tract, kidney function, ear, nose, throat, pelvis, skeletal system, complete blood count and blood chemistry, with Wassermann and Kahn tests not infrequently reveals conditions which aggravate mild ocular defect or are the etiologic factors themselves.

Eye strain alone, due to errors in refraction and muscle imbalance, may cause anorexia, nausea or vomiting, vertigo and epileptoid seizures. The neurologist must help us out here and also in many anomalies and acquired defects in the extrinsic and intrinsic ocular muscles.

The otorhinolaryngologist must eliminate the ear in many ocular muscle defects, especially nystagmus and in some cases of pathologic fundus findings. Disease of the accessory sinuses is a factor in accommodation troubles and in acute and inflammatory conditions of the anterior segment of the eye, the vitreous body, retina, choroid and optic nerve. Infected tonsils are also important sources of systemic toxemia which may manifest itself in the eye as episcleritis, scleritis, or an irritable uveal tract or even retrobulbar neuritis.

The various infections of the external eye require the help of the bacteriologist, who, by examination of smears and cultures, determines the character of the infection and so enables one to apply appropriate treatment.

The pathologist is relied upon for the diagnosis in sections of tumors of the lids, orbital and intraocular growths.

Dermatitis and eczema of the lids, pemphigus and herpes zoster which occasionally attack the eyes by extension, keratosis and epitheliomata of the lids all should have the care of the dermatologist. Likewise, in eye conditions the result of congenital or acquired lues, the systemic treatment should be carried out by the syphilographer.

All penetrating injuries of the eyes should be sent to the roentgenologist to determine if there

is any foreign body within the eye and, if so, to localize same as an aid in its extraction, if magnetic, by means of the magnet. In certain cases of inflammation of the optic nerve knowledge as to the condition of the accessory sinuses is most important, as well as the size of the optic foramini. Impacted molars and apical infection of the teeth must be eliminated in many inflammatory eye conditions. In visual field disturbances, especially with color field changes and enlarged blind spots, the continuity of the sella turcici must be known.

Recurrent episcleritis, scleritis, iritis and chronic low grade inflammation of the uveal tract with vitreous opacities, which do not respond to local treatment usually improve rapidly after clearing up prostatic or cervical and uterine inflammation and infections; hence our dependence on the urologist and gynecologist. Vaccines made from cultures of the secretions from these organs occasionally are necessary to bring about improvement or complete relief.

The brain surgeon is the final resort in conditions where eye symptoms point to increased intracranial tension.

Occasionally impacted teeth, especially in arrested development of the superior maxilla, produce symptoms which manifest themselves as apparent eye strain and relief is only obtained by orthodontal procedures or extraction of the offenders. Likewise, apicial infections require the care of the oral surgeon.

Lordosis, especially when combined with scoliosis, is a factor in producing eye strain as a result of the tilting of the head, which changes the level of the visual axes and bring about a hyperphoria and muscle imbalance which is especially annoying in close use of the eyes. Temporary relief is occasionally given by the use of prisms, but correction of the defect by the orthopedic surgeon, when possible, allows the individual usually to discard the prisms.

The general surgeon is the court of last appeal in removal of sources of infection in the chest and abdominal cavity.

From the above, it must be very apparent the extremely close relationship between ophthalmology and the many special divisions of medicine, and how impossible to give relief to our patients without the fullest cooperation.

Nor are the other departments of medicine entirely independent of the eye man in completing a diagnosis or discovering the first symptoms of some impending or incipient disease. This is especially true in some kidney lesions, the first symptom being blurred vision. The ophthalmoscope here discovers the beginning evidence of albuminuric retinitis. Many cases of diabetes are spotted by the eye man because of the frequent marked changes found necessary in the lenses correcting errors in refraction, as well as evidence of beginning lenticular opacities and diabetic retinitis.

Medicine is a wonderful science, possibly not exact, in our day, but the ability to discover the cause and alleviate the suffering of our fellow men is a God-given privilege in which cooperation among its votaries is most essential.

DISCUSSION

Dr. Shaler Richardson, Jacksonville:

I enjoyed reading Dr. Black's paper very much because I think it shows the very close relationship between all branches of medicine and ophthalmology.

Concerning intracranial lesions, I feel that the ophthalmologist's study of these conditions is so very essential that every brain case or suspected brain case must have a complete ophthalmological study. It is remarkable the number of brain cases that are picked up by the ophthalmologist. Frequently we have patients who consult us complaining of headache and ocular discomfort, and in going over these cases and making the routine ophthalmoscopic examination it is not infrequent that we pick up cases of well advanced papilloedema or even optic nerve changes which have progressed so far as choked discs.

Some few weeks ago a young woman came into my office complaining of a headache. Some years previously she had been a patient of mine for a refracted condition. The headaches were not intense; she simply complained of headache after use of the eyes. Examination showed double choked discs, and this subsequently proved to be an intracranial neoplasm which has recently been operated upon.

Concerning the treatment of syphilitic conditions of the eye, I think it is most important that there be a full cooperation between the syphilographer and the ophthalmologist. In most of these inflammatory conditions of the eye, the use of arsenics in the beginning is contraindicated as it only aggravates the eye condition. I feel that in many of these inflammatory conditions of the eye treated indiscriminately with arsenic in the

beginning, the vision is lost because of this mismanagement of the condition. In all of these cases the use of bismuth and mercury certainly should be concentrated on before any arsenics are used.

I also want to sound a note of warning regarding the use of tryparsamide. For many years there has been developed a condition of contraction in the fields by the use of tryparsamide. The question is whether the very marked contraction one sees in many cases of neurosyphilis treated with tryparsamide is actually due to atrophy of the nerve as a result of syphilis, or to the use of the drug. However, there is no question about it; many of these neurosyphilitic cases treated actively with tryparsamide develop very suddenly a marked contraction of the field of vision, and I don't think that any case of neurosyphilis should be treated with tryparsamide without a constant watching of the fields of vision.

We all lay ourselves open to malpractice suits, and not so long since such a suit was begun in this community. Therefore if we watch the fields closely we are protecting ourselves.

I want to thank you for being able to present this paper of Dr. Black's. I hate to see a program go by without an eye, ear, nose and throat paper, and this was the only paper on this particular subject.

SURGICAL MANAGEMENT OF THYROTOXICOSIS*

John S. Helms, Jr., M.D.,
Tampa.

HISTORICAL

Willard Bartlett has said that we have every reason to believe that goiter is as old as the human race. With very slight reservation this is probably a true and accurate estimation of the age of this most intriguing condition.

Contrary to an almost universal lay belief, operative removal of the thyroid is no longer a procedure in its late infancy but long ago became a standardized surgical practice. Nearly one thousand years ago Albucasis attempted the surgical removal of a goiter and hinted of some previous similar adventure of his or one of his contemporaries.

Somewhat more than nine hundred years later one hundred and six authentic cases had been reported, the majority of which were done prior to the introduction of ether in 1846. The performance of thyroidectomy without adequate anesthesia seems almost inconceivable to us who now have so many anesthetics from which to choose.

It must have been with indomitable courage that the pioneers in thyroid surgery were endowed to tread in such a vulnerable region under such adverse circumstances. The names of Desault and Hodenus should not go unmentioned as outstanding figures up to the time of Kocher, the master. Then, about 1883, began the so-called present era in thyroid surgery during which Kocher, Halsted, C. H. Mayo and George Crile have played the major roles.

MORTALITY

A mortality of twenty to forty per cent must have been most discouraging to even those stout-hearted surgeons of the pre-antiseptic days, who so valiantly blazed the way for the brilliant results of today. With the advent of "Listerism" came a most astounding drop in the mortality rate to between two and eight per cent, until today, the era of asepsis, it is most generally well under one per cent.

ETIOLOGY

For some years there has been more or less agreement among most clinicians of experience that the group of clinical syndromes which point to an alteration of the normal function of the thyroid gland with the production of toxic symptoms may possibly be due to either one, or both, of two conditions; namely:

(1) pure hyperthyroidism, in which there is an excessive secretion of a normal hormone, or

(2) the elaboration of a chemically altered hormone, or

(3) a combination of the two.

The term "thyrotoxicosis" is herein applied to the constitutional state produced by any of these conditions and consequently includes those cases of exophthalmic goiter (Graves' or Basedow's disease) and adenomata with toxicity.

In 1926 George Crile injected the adrenal factor into the hyperthyroid picture and showed very convincingly that hyperadrenalism if not "the" exciting cause of so-called hyperthyroidism was at least intimately dovetailed with it. Marine believes the primary defect to be in the adrenal cortex, the effect of which removes the inhibitory action of these endocrines over the thyroid. Others have indicated a close relation-

*Read before the Sixty-first Annual Meeting of the Florida Medical Association, Jacksonville, April 30, May 1 and 2, 1934.

ship between such glands as the gonads, pituitary and thyroid. These do not, however, minimize the part played by the thyroid or detract from the importance of the hypotheses concerning the nature of the thyroid secretion.

Following the isolation of thyroxin by Kendall in 1914 he discovered the scarcity of iodine in hyperplastic glands. The role of iodine in producing a return toward normal of the anatomically and physiologically deranged thyroid is not clear, particularly since there is no apparent relation between the advent of the disease and iodine deficiency. Therefore, notwithstanding the advances made in the study of the anatomical structure as well as the pathologic physiology associated with thyrotoxicosis, the basic etiologic factor remains undiscovered and Graves' disease continues to be one of our most baffling medical and surgical problems.

PATHOLOGY

The morbid anatomy of the thyroid in Graves' disease and toxic adenomata is fundamentally the same—hyperplasia of the follicular epithelium. In the former it is diffuse, in the latter it may be diffuse but most frequently is limited, and may be encapsulated or non-encapsulated. The diffuse adenomatous type is more correctly called "adenomatosis."

There occasionally is a total lack of epithelial hyperplasia in a patient presenting symptoms of severe thyrotoxicosis, particularly after prolonged iodine therapy.

On the basis of pathology there is no justifiable reason for the distinction clinically between toxic and non-toxic adenomata or between exophthalmic goiter and toxic adenoma. The difference is in degree of change and not in kind.

DIAGNOSIS

It is no difficult matter to arrive at the correct diagnosis in the usual type of thyrotoxic patient with either Graves' disease or adenoma with toxic manifestations. These patients are far more frequently recognized than missed. In the Graves' type there is the diffuse, uniform enlargement of the gland, the tremor, palpitation, tachycardia, muscular weakness, restlessness, loss of weight, sweating, exophthalmos and increased metabolism in addition to innumerable other less well known but fairly constant signs, all developing in a relatively young person in a period of three to six months. As opposed to this group of symptoms, possibly in degree rather than kind, are the manifestations of the clinical type commonly spoken of as toxic adenoma. The patient is relatively older, the symptoms of a more chronic nature, the gland usually nodular, the metabolism lower and the other signs and symptoms proportionately less severe, with the possible exception of the cardiovascular mechanism which has borne the brunt of the disease, due chiefly to its protracted course. It has been my observation that the metabolic measurements in our patients in Florida, even the severely toxic ones, are on an average considerably below those reported in other sections.

A little less easy to recognize is the acute fulminating type which frequently terminates fatally, and the cardiovascular type in which the markedly rapid heart predominates.

Perhaps those larval forms which present most of the usual signs and symptoms of a moderate or severe thyrotoxic state but consistently maintain a metabolism which is normal or subnormal are the ones that tax the ingenuity of the clinical diagnostician to the utmost. These are the patients who, were it not for the telltale goiter, would be relegated to the group of psycho-neurotics and become the football of the local medical fraternity.

Of the clinical laboratory procedures available for use in the study of thyrotoxic patients the metabolism test, of course, holds first place in importance. By an accurate estimation of the basal metabolism correlated with the physical signs and symptoms, one may be reasonably sure in most instances that he is, or is not, dealing with a thyrotoxic patient.

The blood picture is of some value, there being typically a lymphocytosis.

In recent months there has been developed a practical method for the determination of the iodine content of the blood. Curtis, Davis and Phillips have shown that the normal blood iodine content is remarkably constant and that in thyrotoxicosis, whether of the exophthalmic type or the adenomatous type, the iodine content of the blood is definitely increased. If this procedure proves to be as reliable as is indicated by this early work it will be a most valuable addition to the clinicians' diagnostic aids.

TREATMENT

While it is true that the fundamental pathologic physiology of thyrotoxicosis, both of the Graves' type and that of the adenoma, is as yet very poorly

understood, surgical attack directly upon the thyroid remains as the sheet anchor in the treatment of both classes.

It is undoubtedly true that a certain small per cent of these patients, particularly those with the larval or incipient type, will respond favorably and permanently to rest and iodine medication; nevertheless, this is probably not justifiable in more than a small per cent because of the possibility of fanning an already impending conflagration.

Ever since the introduction of iodine by Plummer in 1922 for the preoperative treatment of Graves' disease the question of using this drug in the adenomatous cases has been an open one. There remains little doubt that symptoms due to toxic adenoma far less frequently subside than do those caused by Graves' disease as a result of iodine medication. However, because of the similarity of the fundamental morbid anatomy and because of the likeness of the symptoms and because an appreciable number of adenomas do respond favorably to this drug it is my personal opinion that it should be used, particularly in the acute cases, in the preparation of these patients for operation in the same manner as in Graves' disease.

I shall not enumerate the details of the preoperative preparation but shall only emphasize a few of the most important. It would be difficult indeed to say which is of major importance, rest and quiet, or iodine. Both are absolutely essential in the average case. The choice of iodine preparations is probably of minor importance provided one is selected in which the iodine is readily available. Compound solution of iodine (Lugol's solution) is universally applicable and I have found it satisfactory for both oral and intravenous use.

In the average case it has been my custom to start with small doses, say two or three minims three times daily and increase two or three minims each dose daily until as much as fifteen or twenty minims or more are given at each dose.

In those patients who are particularly refractory to iodine (so-called iodine fast) for one reason or another, a period of complete rest in bed with a high caloric diet for several weeks, or months if necessary, followed by the resumption of iodine will usually be followed by favorable results. The intravenous route is particularly adaptable to these patients and may be used with comparative safety if the solution is well diluted. Ten minims of Lugol's solution added to 500 or 1000 cubic centimeters of normal saline solution containing 5% glucose may safely be given three times a day using the same precautions as in giving any other intravenous medication. Under this routine even the most stubborn cases will frequently respond much more rapidly than under oral medication.

The next question of importance is when to operate upon these patients. In the vast majority of those who have not received iodine before, the optimum time will be between eight and fourteen days following institution of iodine treatment, but not infrequently a longer time than this is required, particularly if iodine is given according to the small, ascending dose method as outlined. Frequent metabolism tests should be made and the operation should be done, regardless of the time, at the peak, or if it can be reasonably ascertained just before the peak is reached under preoperative medical treatment.

The anesthetic is most frequently a matter of the individual surgeon's choice. Personally I believe that satisfactory anesthesia can be obtained by adequate preoperative sedation with one of the barbiturates such as pento-barbital sodium followed by nitrous oxide gas, occasionally suppiemented by novocain and adrenalin locally.

The actual technique of the operation is so well standardized and so adequately described in innumerable textbooks of surgery that I shall merely touch upon a few points of major importance.

The Boekel collar incision, almost universally credited to Kocher, is applicable in all but the most unusual cases. It is important that this be lengthy enough to provide adequate exposure, which is of extreme importance. In addition to this the midribbon muscle split of Kocher, the Halsted treatment of the upper pole, Milkulicz's subtotal resection of the lateral lobes and Mayo's bilateral procedure have stood the test of time and remain today as undisputed points in technique.

Regardless of the degree to which thyroidectomy has been standardized each case is an individual one and should, of course, be so handled. Every operator should be prepared to vary his technique to fit the occasional case in which the usual procedure would be unsuited. Careful hemostasis is most important and extreme delicacy and care are paramount.

COMPLICATIONS

Thyroidectomy is perhaps fraught with as many and as formidable potential complications as any major surgical procedure. It is only necessary to mention such adjacent or contiguous structures as the carotid arteries, the internal jugular veins, the recurrent laryngeal nerves and the parathyroids posteriorly, and the trachea and esophagus medially, to impress upon one the danger of hasty or careless surgery and the absolute necessity for extreme care. The immediate postoperative care of these patients is most important even though comparatively simple. The absolute prohibition of visitors, morphine for pain or restlessness, iodine and fluids by rectum at first, then orally, and the ice bag over the precordium constitute the usual routine.

RESULTS OF SURGERY

The rapidity with which the average thyroidectomized patient responds favorably to surgery, particularly in the type with Graves' syndrome, is little short of miraculous. Within two or three days as a rule, and nearly always within a week, practically all of the cardinal signs and symptoms have diminished with the exception of the exophthalmos, and even this occasionally begins in a week or less. The patient rapidly strengthens and is able and anxious to become active, but should be warned against returning to any occupation in which the mental or physical strain is at all great for a period of at least several months and should be protected from any factor which may possibly have had a part in the initiation of the dysfunction. It has been rather definitely shown that the average patient with Graves' disease, even under the most favorable circumstances, fails to regain a normal physiological status under one year from the time of operation.

RECURRENCE

Recurrence is defined as gland hypertrophy and hyperplasia with return of symptoms following radical treatment and freedom from symptoms.

Recurrence is much more common in adenomatous glands but occurs in the exophtha'mic type in possibly two per cent of cases, and in both types much more frequently in younger patients than in those over forty years of age.

Recurrences shall probably become fewer and thyroidectomy more ideal as a means of curing the thyrotoxic patient as more and more surgeons realize that it is perhaps wiser to remove too much than too little of the gland.

SUMMARY

1. The basic etiology of thyrotoxicosis remains unknown.

2. The fundamental morbid anatomy in Graves' disease and in toxic and non-toxic adenoma is extremely similar.

3. The determination of the iodine content of the blood may become a useful diagnostic procedure when correlated with the clinical features and metabolism test.

4. Treatment is essentially adequate surgery preceded by adequate preparation and followed by extreme care over a period of years.

5. The chief immediate dangers of surgery are hemorrhage, vocal cord paralysis and injury to the parathyroids.

6. Recurrences shall probably be more uncommon as more adequate surgery is done.

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DISCUSSION

Dr. F. J. Waas, Jacksonville:

Dr. Helms certainly has developed a very excellent paper on the history, etiology, diagnosis and surgical treatment of thyrotoxicosis. I am very much impressed with his paper.

Relative to the use of Lugol's solution: When you take into consideration the effect that iodine has of producing involutional changes in the thyroid gland, in other words, developing an entirely different histopathological aspect of the gland, I think it behooves us to be a little bit cautious or to act cautiously in advising iodine. It is a generally accepted fact that iodine has the faculty of stimulating lymphoid hyperplasia. The standard method of ten drops three times a day for eight or ten days will properly safeguard these cases for a more or less successful surgical procedure. It is more or less accepted that it is quite possible to drive a simple non-toxic adenoma to the operating table with symptoms of acute thyrotoxicosis due to the excessive and indiscriminate use of iodine. The symptoms of

acute thyrotoxicosis may be inadvertently due to hyper-iodism. Dr. Crile has justly said that it is possible to produce hyper-iodism and that the symptoms under these circumstances are practically parallel with symptoms of acute thyrotoxicosis.

In the post-operative care, I have not found it necessary to resort to the intravenous use of iodine. However, I have found one excellent method that I do not believe Dr. Helms' has mentioned; that is to give Lugol's solution as hypodermoclysis on the table. I use 4 cc. of Lugol's solution to a thousand cc. of salt solution, and I find this procedure will stabilize the patient for two or three days following the operation, and after that time I think it is best to give Lugol's solution by mouth.

Dr. Helms speaks of the basal metabolism. I do not know how much dependence can be placed on the basal metabolism as so many psychic factors enter into the picture to influence the metabolic output. Absolute quiet and happy surroundings are among the most important factors in estimating basal metabolism. The patient should not be excited and every effort should be put forth to simulate a picture of absolute quiet.

Dr. Helms mentioned the difficulty sometimes in reaching a diagnosis of exophthalmic thyroid. It is not always easy to establish such a diagnosis. I have a patient in St. Vincent's Hospital at the present time who was referred to me by one of our internists with the diagnosis of exophthalmic goiter. Two days after admission to the hospital she showed a basal metabolism of minus 20. The following day a basal metabolism of plus 7. Patient only showed slight evidence of exophthalmus but she was very much excited, rather activated. She showed more or less definite tachycardia, but I was not able to palpate a resistant thyroid gland. It is a question in my mind as to whether I will be able to put this patient within the caption of exophthalmic thyroid. One could consider the activated type as spoken of by Dr. Lahey of Boston. However, I feel that I will be inclined to put this patient within the category of neuro-circulatory asthenia so ably described by Dr. Crile. I mentioned this case with the idea of emphasizing the point Dr. Helms brought out—that it is not always easy to make a diagnosis of exophthalmic goiter.

Thyroid surgery is one phase of surgery that needs the absolute cooperation of the internist and surgeon.

Doctor, I certainly enjoyed your paper and appreciate the privilege of discussing it.

Dr. James M. Hoffman, Pensacola:

The paper of Dr. Helms presents a very comprehensive summary of the "high spots" in this vast subject. The very interesting microscopic pathology of this condition could be discussed for hours. We must remember that the toxic thyroid creates an imbalance in our endocrine system and I would like to call your attention to the thymic hyperplasia which usually is present and may be responsible for some of our operative thyroid deaths. The secondary cardiac pathology is also most interesting to study. These cardiac changes may be due to pressure effects which usually affect the right ventricle by pressure on the trachea or bronchii with consequent emphysema or a chronic passive congestion, by direct pressure on the veins. The true goiter heart however is distinctly thyrotoxic with the train of pathologic changes in the heart muscle which is another big factor in the production of the operative mortality. Do not overlook cancer. In the outlining of any plan of treatment these factors should be considered. We should ever have in mind these autopsy experiences, which would serve us in delineating a safe course of procedure in these cases.

Fortunately, in Pensacola, we see relatively few cases of true thyrotoxicosis. The success of our operative procedure in my opinion is almost in direct ratio to the care exercised in our preoperative management. A good maxim to follow is never to operate on a thyroid on a rising metabolic rate. In my own experience I have seen excellent results follow the judicious use of preoperative radiation in stubborn cases. I personally prefer radium to x-ray and have not seen the excessive amount of adhesions at operation when radiation was carefully administered.

In the actual operative technique let me emphasize again the necessity of adequate removal. Recurrences are invariably the result of allowing too much thyroid tissue to remain but it is not my intention to minimize the dangers of careless technic in this region.

The proximity of the very important structures to the posterior capsule and the inferior thyroid artery has been called to your attention in Dr. Helms' paper. The surgeon in operation on a thyroid must not only be thoroughly conversant with the anatomy and physiology of the area,

but must exercise extreme care, more so than in other operative fields.

In conclusion, I feel that the handling of the surgical thyroid is an individual problem. Each case must be studied on its own merits and the procedure in treatment be outlined with a full knowledge of the pathologic and physiologic variation that present themselves in each individual case.

Dr. J. S. Helms, Jr., Tampa (Concluding):

Perhaps one of the most interesting phases of this question is the etiology. Dr. Crile's theory, as I understand it, is that at times at least it is one of the neurogenic diseases and may be cured by adrenalectomy in certain selected cases. He has shown or stated that he has cured nineteen cases of hyperthyroidism by adrenalectomy without operating upon the thyroid. Most men, I think, will be a little hesitant to accept that, although he has rather definitely shown it. The interesting thing is that he feels the adrenal sympathetic system is probably responsible in quite a large percentage of cases of hyperthyroidism.

SOME INTERESTING PHASES IN THE PRACTICE OF PROCTOLOGY*

JACK HALTON, M.D.,
Tampa.

We hear from such reliable sources as students of Biblical history and of ancient tongues that one of the seven plagues of the Egyptians was the plague of hemorrhoids. It is certainly not my intention to trace for you the history of the practice of proctology from such ancient days. Suffice it to say, that whatever may have been its standing as a branch of medicine in the days of the Ptolemys, or even in the days of Rome's splendor, the practice did fall into disrepute. This now recognized specialty was, in the beginning, associated in the minds of the profession with the practice of charlatans and quacks to a degree which for years handicapped its development. This limited its membership. because of the suspicion with which they were regarded, to those intensely optimistic men of far vision and pioneer metal who could work, satisfied with some progress, and who were spurred on rather than hampered by the opposition of the medical fraternity as a whole.

I will show you that this lack of understanding has, in a large measure, opened the way for the exploitation of this branch of medical science in a degree greater and more shameful than that suffered by any other specialty. I will point out to you how this invasion of the practice of medicine by fakers and insufficiently educated men is at once acquiesced in—even fostered and promoted by—the very men who would be the first, in any specialty of which they had more knowledge, to stop the invasion of this army of cheats. In other words, the ethical men of our county societies, of the American Medical Association, are admitting into their offices the so-called experts (salesmen really) those of the electrical and instrumental supply houses advertising specialists of the so-denominated colleges of proctology, and societies for the promotion of ambulant proctology whose aim is the commercialization of this work and the sale of remedies.

It shall also be my purpose to state, briefly, the scope of this specialty; to show it legitimately divided into two distinct schools, which are, nevertheless, reconcilable since their aims are the same (*i. e.*, the school which swears by surgery, and that which swears at it and will treat only by injection, application, etc.) ; and to show that each method has its rightful place and how it is to be distinguished.

In conclusion, I will present for your consideration, in slides made from x-ray films, the result of the practical application of method to a condition fairly frequent, sometimes unrecognized, sometimes mis-diagnosed, always progressive, almost never helped by ordinary methods used by the general practitioner, usually neglected until the patient is in dire straits, yet generally amenable to one form of treatment which is not surgery, for surgery would condemn the patient to discomfort ended only by death.

Proctology, or the treatment of rectal pathology, is a practically new specialty. That is to say, that while for long years men have confined themselves to the treatment of diseases of the "other end" and kings and commoners alike have sought them out for such relief as they, almost alone of the Brethren, knew how to give, there was a great deal of aversion to its practice. The man who chose it was regarded with so much suspicion, that men of standing avoided recognition of the insistent need for definite knowledge of the anatomy and pathology of that part of the body. They examined with reluctance conditions so patently pathological that they could not avoid at least some attempt at palliative

*Read before Fourteenth Annual Meeting Florida Railway Surgeons' Association, Hollywood, May 1, 1933.

treatment, and especially opposed any non-operative treatment, since the opposition of the general surgeon to other than radical treatment for these cases was marked.

About fifty years ago a change in attitude towards study in this particular line became apparent. I quote Walter Fansler, F.A.C.S., Professor of Surgery, University of Minnesota, an active Fellow and a past president of the American Proctologic Society:

"With rectal diseases neglected or poorly treated by the profession the field was ripe for any one offering a method which avoided operation. About 1891 the injection method for treatment of hemorrhoids came into being. It was heralded as a bloodless, painless, non-surgical method of cure. Even as crudely as it was done, I think I would rather have taken a chance on the injection than on the surgery as it was done at that time, in fact, than upon some of the (rectal) surgery I have seen more recently. The surgeons at once decried this method, and since the general practitioner and interne usually referred rectal cases to the surgeon for operation, they were influenced by the surgeon's opinion and fell into line. It was the usual 'dog in the manger' attitude. They condemned this method without adequate investigation and refused to develop their own surgical treatment to a point where it compared favorably in technique and results to surgery done on other parts of the body. You may not agree with the injection treatment of hemorrhoids but there is no doubt that from this method came the real beginning of the development of the specialty of proctology as a distinct branch of medicine."

You may be very certain that the reluctance of the general practitioner to examine the rectum, or to recognize symptoms of rectal pathology, his indifference to the need for a study of diseased conditions of the rectum, his aversion to discussion of treatments and refusal to examine into the merits of methods developed by the persistence of a few hardy pioneers in the work, opened wide the door of opportunity to a type of adventurer still numerous, still noticeably prosperous even in these years of depression. I refer to the "pile specialist," who with his advertising, secret formulae, guaranteed cure, and absolute disregard of the most elementary ethics of the profession, invaded every city and town, some only temporarily until the harvest was reaped, some—alas!—to flourish, although viewed with distaste. Well-equipped and most profitable institutions sprang up under the very windows of those ethical and conservative physicians whose sensitive noses, atip to an odor which they ascribe to all of the tribe, failed to differentiate between those at fault and those whose licenses to do the same work, if in other manner, are preserved in cleanly places.

Yet it is among these ethical men and their families, who know not where to find relief among those of their own kind, that the irregular gets many of his patients. I refer to places like the much-advertised Rectal Institute. It is to the irregular, to the members of so-called "colleges of ambulant proctology," pandering to the commercial side of proctology, or to institutions fostered by them, that the ethical general practitioner has recourse when he desires to learn something about rectal work. For these men, with their generous offers of clinic instruction, secret methods and formulae, guarantees of success, and, in these days of hard won money, increased cash practice, raise their voices and make themselves known and accessible; while in few places and very quietly the ethical proctologist mumbles into his sleeve of the happy results of his pet treatments or long research, and hopes, wistfully, that he may find someone, sometime, who'd be a little bit interested in some of the things he is doing.

In spite of the suspicion, owing to the activity of the irregulars, with which every honest proctologist was regarded, a few of the hardier souls among those interested in the new specialty got together and in 1899 formed an ethical organization for the dissemination of information and protection of members doing rectal work. Since then, with membership carefully restricted to the few whose work lies entirely in this field and is of sufficient merit to win approval after all requirements of education and practical experience and time of probation have been met, the American Proctologic Society has won for the specialty, and for itself, a distinct place and recognition as a section of the American Medical Association.

Yet, because of its very conservatism the way has remained open for representatives of unethical societies, representatives and salesmen from various electrical and instrument supply houses and makers of therapeutic products to abuse the confidence of the layman, the uninformed medical man, occasionally the ethical institution, through the assumption of knowledge and authority they do not possess.

It comes to my mind, as an instance of the way

these people work, that a member of my own county society on occasion sent to his fellow-members announcements of the intended visit of a certain specialist or expert in the treatment of rectal conditions by the electro-therapeutic method, inviting them to be present at a clinic which he would hold for their instruction. The possibilities drew my attention and I went, on the day set, all primed for some fun (I have watched these babies for years)—to find myself confronting a self-styled expert whose establishment of a physiotherapeutic institution in Tampa was so run as to earn the condemnation of his confreres and resulted in his expulsion from the county society. Later he had affiliated himself with a manufacturer of electrical apparatus. He had the effrontery to suggest, when I penetrated a disguise of whiskers and addressed him by his rightful name, that he could teach me a lot of new methods and, most wonderful of all, how to triple my income. Yet, after I had exposed the man to the members of my own county and neighboring county societies, a member of a neighboring county society furnished clinic material and office to this man, and, I judge, paid for a machine to use on his patients and for a course of instruction as well. Many of these patients so treated come my way eventually, which is a satisfaction—if you look at it that way—but there's not so much fun in patching up a bungled job. The patient is nervous, he has lost faith in anyone's ability to cure him, and comes only because he is seeking desperately for some—any—relief. And he is, by that time, short of funds and not sure anyhow that he ought to pay for work that probably won't help him.

As time goes on, more and more conditions which were formerly considered amenable to surgery only are being brought within the scope of the non-confining office treatment. In this category is the treatment of hemorrhoids, by injection, whether by phenol and Wesson oil or by quinine and urea solution, a method satisfactory in every case if the technique is correct; the treatment of fissure, also by quinine and urea injection; pruritus ani, either by Benacol or hydrochloric acid treatment (Haynes method); contracted, or tight, sphincter (divulsion here is not always necessary); proctitis, rectal prolapse. These all respond to office treatment. Your patient is free to be about his business and has no hospital fees to pay. These treatments are practically painless and bloodless—successful treatments. Likewise is the treatment of stricture of the anus and rectum by the application of carbon-dioxide snow, as the slides I will show you will confirm.

All other rectal pathology must be treated surgically. These conditions are, most frequently, external piles, thrombi, skin tags, cryptitis, fistulas, abscesses, condylomas, enlarged valves of Houston, and adenocarcinomas (except under those conditions already too far advanced for operation, when the carbon-dioxide snow treatment will prolong the patient's life in comfort.)

Success in the non-operative treatments lies, not in selection of cases, as many would have you believe, but in thorough mastery of technique and in versatility of the operator in adapting that technique to the individual case.

Ointments, suppositories, oils and jellies are means of temporary relief, not to be ignored, but never to be considered curative; nor by their continued use is the positive treatment of any condition to be neglected.

Again I stress to you the value of early and complete examination of the whole rectal tract whenever there is cause to believe it may reveal some pathology. Would it surprise you to hear that one case of long continued and aggravated twitching of the eyes responded beautifully to treatment for tight sphincter? Nor was that by any means an isolated case. Many patients afflicted with other forms of nervous disease are relieved or improved by attention to rectal conditions of which they never dreamed of complaining. How many times are the cases of painful menstruation the result of sagging colon, or of impacted feces in the rectal pouch? Much of this pain caused by rectal pathology is, apparently, related not at all to that part and unless examination is done, as a matter of routine, conditions which should be corrected are not even seen. That bug-bear of the railroad surgeon, "pain in the back", proceeds in many cases—surprisingly many—from hemorrhoids or other rectal conditions.

Beware of bleeding from the rectum. Many patients neglect it for a long period before reporting to their physicians for examination. Then, if the physician is not versed in the use of the proctoscope and sigmoidoscope, or neglects their use, serious hemorrhage and profound anemia may result before the source of the trouble is discovered. Adenocarcinoma is often unrecognized until it is too late. It is surprising how many cases of so-called "bleeding piles" turn out to be adenocarcinomas; how many times



View I.
Dec. 23, 1932.
Mrs. ———, age 39.
Weight 94 lbs.
Tubular stricture, multiple fistula, duration 20 years.
Laboratory tests negative.



View II.
Jan. 10, 1933.
After 2nd treatment carbon-dioxide snow.
Showing smallest size frigidor through narrowest part of strictured area.

they are polypoid growths. When in doubt, a biopsy should always be done.

In presenting to you these reports on two cases of rectal stricture, I am going to let the pictures speak for themselves, except to tell you I am very much gratified to have been able to get "before and after" records, since it is extremely hard to convince these patients they should continue treatment after they believe they are well.

These cases you see have responded to non-operative treatment by carbon-dioxide snow, a method originated by Dr. E. J. Clemons of Los Angeles, in whose hands it has proved a consistently successful method of permanently relieving patients suffering from anal or rectal stricture, both benign and malignant. The author of this paper is deeply indebted to Dr. Clemons for his patient encouragement and valuable assistance.

My own experience has been so satisfying that for a period of ten years I have not done a single proctotomy, or other form of surgery for these conditions.

Both of these cases were tubular strictures, the more difficult type of stricture to reduce, one of about eight years' and the other of about twenty years' standing. Regarding these prints which I am showing you, a telegram dated April 26, 1933, from Dr. Clemons says: "The prints speak for themselves. Congratulations without further comments."

To sum up will take only a minute. My effort has been to show that the ethical treatment of rectal diseases has been a practice which has grown, in spite of continual conflict with an army of charlatans whose methods have cast a shadow of greed over it; in spite of the disapproval of the general man who could not understand how the seemingly almost miraculous results obtained by the rectal specialist (for these cases do show, occasionally, almost unbelievable results), could be obtained by any legitimate methods; in spite of the natural desire of an uninformed public to be told where to get relief and to be guaranteed a cure.

I have endeavored to show that this specialty, handicapped, still young, little taught, is, in the hands of earnest workers, assuming an ability and an authority in the treatment of all forms of rectal diseases which enables it to devise instruments to fit its peculiar necessities and to produce, as these few slides must example, results that we are modestly proud of and which we hope, not so modestly, to impress upon the minds of the medical profession at large, as consistently possible in the hands of men whose study and devotion to this specialty is their life work.

Credit is due to the following men for the development of the methods noted:

Injection treatment of hemorrhoids by quinine and urea, E. H. Terrell, M. D., Richmond, Va.; by phenol, Collier F. Martin, M. D., Philadelphia, Penna.; by phenol and oil, Marion C. Pruitt, M. D., Atlanta, Ga.

Treatment of anal fissure, Alois B. Graham, M. D., Indianapolis, Ind.

Treatment of benign and malignant strictures by carbon-dioxide snow, E. Jay Clemons, M. D., Los Angeles, Calif.

Treatment of anal pruritus, Granville S. Hanes, M. D., Louisville, Ky.

DISCUSSION

Dr. Leigh F. Robinson, Ft. Lauderdale:

I consider it a privilege to have an opportunity to discuss Dr. Halton's very interesting paper.

Several years ago while an officer in the U. S. Navy I had the good fortune to be placed in charge of a civil hospital in the tropics. As in any general hospital located in the tropics a large percentage of the diseases were referable to the colon and rectum. We had a good staff of physicians and surgeons but it seemed that none of us were sufficiently interested in the patients that had sick colons and rectums. I soon found that the patients whose pathology appeared to be located in the gall-bladder, thyroid, genito-urinary tract, or pelvis were given more thorough examinations and scheduled ahead of the colon and rectal patients. A recapitulation caused me to realize that the slighting of these cases was due to the lack of interest. To correct this I formed a colon and rectal clinic and made it a routine that every such case have proper x-ray studies and sigmoidoscopic examinations. I don't think that in the beginning I particularly enjoyed making proctoscopic examinations, but when I found the vast amount of pathology that could be discovered only by this type of examination, I no longer complained. This was back in 1920, but to this day, although my practice is largely general surgery, I believe that my viewpoint in my rectal and colon work is that of the proctologist.

I think that we are all ready to agree with Dr.



View III.
Feb. 10, 1933.
After 3rd
treatment
carbon-dioxide
snow.
Large frigidor
all the way
through stricture.



View IV.
March 29 1933.
No. 8 Wales
bougie
in situ.
Relaxation
continues.
Patient now
weighs 112 lbs.
Daily stools
normal size.

Halton that the average physician has very little interest in the rectum. As a result it has been difficult for the rectal patient to get the proper consideration of his ailment. It has naturally followed that he sooner or later would fall prey to the methods of quackery. Therefore proctology has offered a fertile field to be exploited by the charlatan and quack. It was back in the early nineties that quackery in diseases of the rectum found its hey-day. At that time the injection treatment came into more general use. It was heralded as bloodless, painless, and non-surgical. No wonder it was popular, because the information gathered from the literature indicates it was probably safer than the rectal surgery being done during this period. It was only natural that these methods of the charlatan would cast suspicion on any ethical physician who might desire to practice proctology. The few honest gentlemen who had specialized in proctology during those years watched the quack become more bold as he continued in his exploitation of the public. Pressed by conditions, these pioneers in modern proctology organized the American Proctologic Society, the object of which is the "investigation and dissemination of knowledge relating to the rectum, anus, and colon." This organization has been able to place the proper importance on the diagnosis and treatment of these diseases. The result has been noteworthy. The charlatan in proctology is gradually disappearing. He is being rapidly replaced by the ethical proctologist in whom both the profession and the public has confidence. In closing let me congratulate Dr. Halton for bringing out so clearly the fact that non-operative procedures have a place in the practice of proctology.

CANCER OF THE LARYNX*

CORNELIUS G. COAKLEY, M.D.,
New York.

Your committee has requested that I discuss the diagnosis and treatment of cancer of the larynx.

Cancer of the larynx may be confined entirely within the larynx involving the vocal cords, ventricular bands or sub-glottic region, in which case we classify it as intrinsic; or it may involve the epiglottis, the ary-epiglottic folds, the pyriform fossae, or the posterior surface of the cricoid. Such cases are known as extrinsic cancer of the larynx. Intrinsic cancer often in the latter stage becomes also extrinsic. The intrinsic cancer occurs more frequently than does the extrinsic. The first and only symptom of an intrinsic cancer of the larynx is an alteration in the voice. This, at first, may be only slightly husky, but after some weeks it is fairly constant and increases to the extent where it is only a whispered voice. As the lumen of the larynx becomes filled up with the gradually increasing mass, there comes a difficulty in breathing and in the later stages so greatly is breathing interfered with that a tracheotomy may be necessary. When ulceration of the malignant tumor occurs pain referred to the ear or mastoid region is a fairly frequent symptom. In my experience many a patient pays little or no attention to the hoarseness and does not apply for treatment until this painful sensation has developed. The progress in many of these intrinsic cases is slow, and it is not at all unusual for a patient to apply for an examination only after several months have elapsed from the on-set of the hoarseness. Laryngologists often make local applications to the thick inflamed cord for weeks or months with no beneficial results to the patient and a consequent loss of valuable time, thus making necessary a more serious and extensive operation to effect a cure.

In cases of intrinsic cancer of the larynx enlargement of the cervical lymph nodes does not occur until either invasion of the cartilage of the larynx has taken place or the disease has extended outside of the larynx and becomes of the extrinsic variety.

In cases of extrinsic cancer of the larynx, the first symptom is usually some interference with the function of swallowing, either the sensation of a slight lump in the throat or else pain on swallowing and pain referred to the ear. Voice changes are not common in the early stages. Inasmuch, therefore, as pain occurs fairly early in extrinsic cases, as compared with the intrinsic variety, these cases are usually seen at a much earlier stage of the disease than those of the intrinsic variety.

Intrinsic Cancer of the Larynx: Any adult who has hoarseness or aphonia lasting more than a couple of weeks should be given to understand that it is a condition the cause of which should be accurately determined. It is rare to have an acute inflammation of the larynx, which also produces hoarseness, last more than a couple of weeks if the individual observes ordinary precau-

*Lecture delivered at First Post-Graduate Medical Course, Gainesville, June 19-24, 1933.

tions in resting the voice. It is therefore absolutely necessary for a complete and thorough examination of the larynx of any patient with huskiness of the voice. There are many intrinsic lesions of the larynx that cause hoarseness, such as acute laryngitis, chronic laryngitis, abscess of the larynx, membranous laryngitis and many other benign tumors, such as hematoma, fibroma, papilloma, polyp, angioma, cyst, lipoma, myoma, chondroma, osteoma and thyroid tumor. Paralysis of one or both vocal cords results in a hoarseness. Finally, tuberculosis and gumma are to be considered as frequent causes of hoarseness.

Inflammatory lesions always present a very different picture, easily differentiated from the tumors and paralysis by the fact that the changes within the larynx are mainly, if not quite, uniform on both sides whether involving the vocal cords or the ventricular bands. Redness, thickening and indurations are always nearly symmetrical on the two sides. On the other hand in the case of benign tumor of the larynx the lesion is limited to one small area of the vocal cord or ventricular band. The rest of the larynx has nearly a normal appearance. These tumors produce hoarseness merely by mechanical interference with the proper approximation of the vocal cords.

There are three lesions, namely, cancer, tuberculosis and gumma, which in their earlier stages, at any rate, are limited to one vocal cord or ventricular band. The opposite side of the larynx presents a normal appearance. It remains then to differentiate between these three lesions. In the case of laryngeal tuberculosis this lesion is one of the late manifestations following a pulmonary tuberculosis, and a thorough physical examination of the chest, an x-ray of the chest and an examination of the sputum, is almost always sufficient to make a positive diagnosis. The laryngeal appearance of tuberculosis is almost always accompanied by a certain amount of edema of the ary-epiglottic fold with a typical pear-shaped swelling, the large end of the swelling directed towards the middle line. In gumma of the larynx the tumor formation before ulceration is more apt to be on the ventricular band. There is seldom much edema of the ary-epiglottic folds; chest and sputum examinations are negative for tubercle bacilli, and the Wassermann reaction will be found to be positive. In the case of cancer of the larynx, tests for tuberculosis and syphilis will be negative. Given therefore a thickening and induration of *one* vocal cord, and in the absence of tuberculosis or other symptoms, one strongly suspects a malignant invasion. This suspicion should not be left in doubt, but immediate steps taken by means of a biopsy to determine the real nature of the lesion. This biopsy can only be done by one who is competent to make such an examination, and I believe that most of the biopsies should now be done by direct laryngoscopy, because then one can be pretty sure of securing a large enough specimen, and from the most favorable site which should include the edge of any ulceration and into adjacent non-ulcerative area. A competent pathologist would then have a sufficiently large specimen to be able to definitely report upon the character of the lesion. Not only do the pathologists at the present time report upon the character of the lesion, but from the histological structures they will grade the disease as being radio-resistant or radio-sensitive. Dr. A. P. Stout, director of the Department of Clinical Pathology at Presbyterian Hospital, New York City, has given me his classification for determining whether the tumor is apt to be favorably or unfavorably affected by x-ray as follows:

HISTOLOGY

THE MICROSCOPICAL STRUCTURE OF EPITHELIOMA IS THE MOST IMPORTANT SINGLE FACTOR INFLUENCING THE EFFECT OF RADIOTHERAPY.

Histologic characteristics suggesting probable reaction to radiation.	1. Radio-resistant.	2. Radio-sensitive.	3. Combination of Nos. 1 and 2.
Differentiation.	Present.	Absent.	Radio-sensitivity depends which of the 2 predominates.
Cells.	Adult.	Embryonal.	
Size and staining quality of cells and nuclei.	Uniform.	Varying.	Biopsy showing mainly Nos. 1 or 2 may be misleading.
Intercellular bridges.	Present.	Absent.	
Keratinization and epithelial pearls.	Present.	Absent.	
Mitoses.	Rare.	Numerous.	

Extrinsic Cancer of the Larynx: These are usually already ulcerated when first presenting themselves for examination and we have therefore an ulceration of the epiglottis or ary-epiglottic fold, in the pyriform fossae or the posterior surface of the cricoid. Usually fairly early in the disease there can be felt enlarged cervical lymph nodes; in fact we have known cases where only the swelling of the lymph nodes in the neck caused the patient to seek a physician's advice. Whenever, therefore, one finds enlarged lymph nodes in the region of the angle of the jaw or below it alongside of the larynx, one should expect to find the cause for these enlargements, in some lesion in the naso-pharynx, oro-pharynx, pharynx, including the tongue, or in an extrinsic lesion of the larynx; ulcerations other than those due to malignancy may be from Vincent's organism, tuberculosis or gumma. It is much easier to procure a specimen for biopsy in the extrinsic varieties of cancer than in the intrinsic varieties. A curved biting forceps is all that is necessary.

Treatment: Intrinsic cancer of the larynx is much more apt to be of the type that is radio-resistant than those which are extrinsic. Consequently we feel that the best method of caring for these cases is surgical removal. If the lesion be very small and confined to one vocal cord, and there be no interference with the movement of the cord, a thyrotomy and excision of the growth has proved to be very effective in curing a considerable proportion of cases. If, on the other hand, the lesion involves the entire cord and there is an absence of movement of that vocal cord it will invariably be found that there is a considerable depth to the invasion, and in these cases nothing less than a total laryngectomy should be undertaken. The technique of this operation and the results obtained by the modern method of operation have been so perfected that this operation does not carry the high mortality that it formerly did. The use of an artificial larynx will permit most of these patients to carry on their vocation nearly as well as they formerly did. In the extrinsic cancers of the larynx owing to the early involvement of the lymph nodes of the neck, one has to decide between a total laryngectomy, accompanied by a block dissection of all of the lymph structures in the neck, or the use of x-ray to control the lesion. The results of surgical operation for cancer in this region are not very encouraging. They all have to have a laryngectomy and the percentage of recurrences is very high. During the last three years we have seen several cases treated by deep x-ray therapy where the report of the lesion was that it was radio-sensitive, and these cases have done very well. There has been an entire disappearance of the mass and a restoration of the functions of the larynx and pharynx. We have had other cases where the pathological report showed some question as to what effect x-ray would have on the mass. While a very few of these cases have apparently been cured, most of them were relieved for a few months only to have recurrence take place and the disease eventually result in the death of the patient.

When the pathologist reports a sarcoma, either intrinsic or more frequently extrinsic, the prognosis is exceedingly grave. While the sarcomata usually melt away very rapidly with the x-ray therapy, metastasis occurs in the lung, abdomen, bones or brain, and the patient succumbs to the secondary invasions quite rapidly.

THE ESSENTIAL FEATURES IN DIAGNOSIS AND TREATMENT OF ACUTE FRACTURES OF THE SKULL*

J. Ralston Wells, M.D.,
Daytona Beach.

Acute fractures differ considerably from old fractures of the skull both in symptoms and treatment. For this discussion, we will confine ourselves to the syndrome of acute traumatic fracture.

It is taken for granted that our discussion is entirely on the hardened skull. The infant's skull has, in proportion, less fracture and more brain damage for any given blow. We will, since this is a special subject, not consider the infant skull at this time.

The term "fracture of the skull" is used here only to remark on its fallacy as a designating term. In the surgery of today, we are not concerned in the "fracture of the skull" per se, except where the fracture is the actual cause of a brain injury, *i.e.*, depression, spicule, etc., but we are concerned by the degree and the kind of injury to the intracranial contents. The first consideration is how much and what kind of an intracranial injury is present, or more important, will be present. Our ability to see ahead of present symptoms spells, in many instances, the life of the patient. We must make an early diagnosis.

*Read before the Central Florida Medical Association, Gainesville, October 20, 1933.

By "early diagnosis," I do not mean necessarily early after the accident, but early in regards to onset of serious symptoms which may be indicative or conclusive of diagnosis, treatment and prognosis.

Many different classifications of fractures of the skull may be found, but I think all classifications should be disregarded insofar as treatment, or prognosis, is concerned, and each case judged on its own merits. The two kinds of fractures that should be recognized and treated accordingly are not peculiar to skull; however, they are here more serious because of the probable associated brain lesion. They are a compound fracture and a fracture with displacement of a part, or spicule. These should be recognized and treated recognizing the cerebral complications possible. To know the type of fracture is academically fine, but aside from the fact that a basal fracture without bony displacement usually denotes a more severe blow, thus more trauma to the brain, and a probable opening into a sinus, more injury and danger of infection to the intracranial contents, it is of no especial importance. Most serious traumatic brain lesions are in the presence of a fracture of the base and the symptoms usually make your diagnosis. Injury to the brain may occur without a fracture of the bony skull, i.e., contusion, concussion and even laceration.

The construction of the vault of the skull is that of layers so constructed that shattering is most unusual. This idea of laminated layers has been used practically by the manufacturers of shatter-proof glass. Because of the different construction and shape of the bones of the vault and the bones of the base, we often do have a trauma to the vault with resultant fracture of the base and injury of the basal part of the brain. It is not necessarily true that the heavier the blow, or trauma, the greater the damage. A small object propelled with great force may only make a local injury. A larger object, or a fall, may be less in force, but result in greater damage. Again, a vault fracture may be second to a trauma, or concussion of the brain, and be of no more consequence. A basal line of fracture may cross the paranasal, or the mastoid sinuses, or the body of the sphenoid bone. Here it opens up avenues for bacteria to enter, and openings in the large reservoirs of cerebrospinal fluid, or blood vessels (meningeal and carotids). This type of fracture is serious from several angles, but particularly because there is no surrounding soft parts that might automatically seal the fistulous tracts to retain blood or fluid, or to keep out infection.

Before considering symptoms, one more basic group of facts must be remembered. The brain is a soft mass, the skull an unyielding container. Any bulk that is added to the soft mass must necessarily make pressure upon this mass, and give rise to pressure symptoms. Following any trauma to the brain, as in any other part of the body, we have edema and possibly hemorrhage. Extradural, cerebral hemorrhage, or brain (cerebral) edema, all increase pressure, and these factors usually give rise to the various smyptoms that we can classify, use as a diagnosis and as an indication for treatment.

Symptoms of intracranial injury are many and differ, as one individual does from another. There are a few symptoms to be looked for in our first rapid examination that are basic: 1st, serum or bloody serum from any of the natural orifices; 2nd, consciousness, or unconsciousness, or if some little time has elapsed before you see the patient and the patient is unconscious, has this state been constant, or has there been a lucid interval; 3rd, state of the pupils: dilated bilateral, dilated unilateral, fixed or not fixed; 4th, respirations, and closely linked are the pulse, temperature and blood pressure; 5th, state of being: relaxed unconscious, relaxed conscious, or restless with either consciousness or unconsciousness; 6th, vomiting: present, past, or not at all; 7th, convulsions present, or absent; if present, the kind and areas, and in what sequence as to anatomical distribution; 8th, reflexes including paraplegia, exaggeration, involuntary urination and/or defecation, etc. All of the above must be quickly summed up and differentiated, if and when possible, from simple traumatic shock. All symptoms, except those of extradural increasing hemorrhage, can be summed up, a diagnosis made, a course of treatment mapped out, and no special hurry, except for shock treatment, is necessary. In an extradural hemorrhage, however, speed of active operative measures generally means the life, or death, of the patient. If a patient has been momentarily unconscious, then regains consciousness and walks off only to slowly again lose consciousness within a few minutes, or an hour (this interval may upon rare occasions be many hours in extent) quick action is imperative.

Extradural hemorrhage: the term "extradural

hemorrhage" is used usually to designate a bleeding or torn middle meningeal artery. The above general examination must be made, noting especially the three cardinal signs, one or more of which are usually found in extradural hemorrhage: 1st, patient is unconscious, lucid interval between unconsciousness; 2nd, a loss of motor reflexes over the opposite side of the body to the brain lesion, becoming more profound, and 3rd, Jacksonian convulsions. In order: the lucid interval is the recovery from the initial trauma, the second unconsciousness is a result of hemorrhage making pressure on a local area. A very severe concussion may mask this lucid interval to apparent complete absence. Motor weakness, or loss, is always progressive as the hemorrhage progresses and always starts in the face, spreading to the arm, then leg. Convulsions are from the same cause, and in the same order as the motor weakness. The warning here is to take notice of slight weakness and slight twitchings of the face and do not watch too long. Aside from this one diagnosis, all other acute traumatic brain injuries can be termed as resulting in intracranial pressure with the various general and/or localizing signs. Loss of consciousness transient, or for several weeks, indicates at first trauma (concussion), and later pressure. A deepening coma is alarming, a lessening coma encouraging. The supraorbital nerve pressure test is of much use here. A graph of Temperature-Pulse-Respirations-Blood Pressure should be made and kept at ½-1 hour intervals during the first hours. These should be taken by the same two or three persons in attendance (this latter to rule out normal personal differences.)

With a steady pulse and regular respirations, a mild rise in temperature and a fairly steady blood pressure, all is well. But with a slowing pulse, a deepening slowing respiratory rate, or a cyclic (Cheyne-Stokes) syndrome, together with a rising temperature (over 101°F.), and a rising pulse pressure, we have a grave degree of pressure developing. Also, when we have a persistent rising pulse rate becoming less full, and more thready, a rising respiratory rate more shallow, a rising temperature, and a rising pulse pressure, we are approaching a very dangerous intracranial pressure, and the breaking point in compensation. Something more than has been done must be instituted. When a slowing pulse rate crosses a rising pulse pressure line, and a temperature rising but too early for a rise from an infection, radical relief is imperative. Pupillary reflex changes, hemiplegias, vomiting, changes in deep reflexes, meningeal injuries, blindness, and other cranial nerve effects are of importance, but usually only as aids to localization of injuries, and as focal operative guides.

Treatment: treat, or regulate, or rule out initial shock. Dependent absolutely upon the diagnosis, we have two radically different treatments: 1st, immediate operative or, 2nd, watchful active palliation, with or without later operative procedures. Immediate operative for extradural hemorrhage, remembering the signs are contralateral to the lesion; if doubt exists, or the side not determined, a small opening into the temporal area will quickly dispell doubt and do no harm if no hemorrhage is found; waiting and doubt may cost a life. Operate boldly, rongeur radically, remove and irrigate the extradural clot, ligate the bleeding vessel at the lowest point possible, and usually do not drain, at most not over twenty-four hours.

The second line of treatment is that of controlling intracranial pressure: active palliative and active operative. Active palliative briefly comprises short interval check ups and efforts to reduce pressure. We have several in use: lumbar puncture, rectal injection of magnesium sulphate and intravenous injections of magnesium sulphate, or hypertonic sodium chloride.

I have purposely left out lumbar puncture in the entire diagnostic symptomatology. It is a procedure to be condemned in acute brain injuries. It does not give any information that can not be otherwise obtained; it may alter the brain mass to accommodate the new change in pressure, thus accelerating and increasing cerebral edema by releasing pressure, and for the same reason may keep up, or restart, hemorrhage; it can not drain the subdural space because the arachnoid membrane intervenes. To gain a short time, for one reason or another, after operation is definitely decided upon, or to definitely clear up a confusion as to the existence of

grave, and probable, operative pressure, usually over 18 mm. Hg, it is permissible. Hypertonic, intravenous solutions are to be condemned for approximately the same reasons as lumbar puncture. The rectal installations of magnesium sulphate, one to two ounces of saturated solution every 3-4 hours, does no harm; does not act as a purgative for several days, and in numerous instances, I have definitely seen intracranial pressure controlled by this method, when operative methods appeared almost imperative.

Active operative: when pressure rises to a dangerous level, in spite of the best treatment, institute operative measures. These measures are so varied, and depending on localizing signs, so different, that this subject constitutes in itself a separate discussion. Suffice—a subtemporal decompression is usual and should not be done prior to 6-8 hours post-traumatic because of bleeding, etc. Meningitis, or infection, from a compound wound, is also a separate subject. It rarely occurs inside of 24-48 hours, does not enter into our initial symptomatology, and its best treatment is prevention.

In conclusion: accurate diagnosis as to presence or absence of increasing extradural hemorrhage—if positive operate promptly. If the above diagnosis is ruled out, all skull and/or brain injuries should be placed at absolute rest physically, and insofar as possible the same for all special senses. Special nursing, or care, is imperative for the first day or so. Start immediately accurate chart records, graphic preferred; magnesium sulphate by rectum; ice to the head and back of neck constantly; turn patient to one side or the other to avoid inspiration of mucus and blood, etc.; keep bleeding orifices clean with antiseptic solutions, do not pack or plug tightly, but rather encourage drainage if not too severe; avoid morphine and other strong sedatives—they may and do mask early symptoms. Extreme restlessness usually means great intracranial pressure and often is the forerunner of coma. Only when the other signs of pressure are satisfactory, or when consciousness is so acute as to be aware of other painful injuries, may morphine be given. At times, full doses of bromides by rectum are permissible. Cardiac stimulants, unless in the presence of a known cardiac organic lesion, are contraindicated as they may tend to raise blood and intracranial pressure, and cerebral congestion. Atropine, whiskey, and strychnine—never; camphor, in first few hours to counteract general traumatic or exposure shock is good at times. Hot enemas and catheterization of the bladder are permissible at any time. Never do lumbar punctures, or use intravenous blood pressure reducing agents, except just prior to operative procedures. If they are used at this time, and pressure is thereby satisfactorily reduced before operation, do not change your mind—operate; the improvement is temporary, and all pressure signs will return, probably increased, within a short time.

Discussion, or inclusion, of x-ray examinations has been purposely avoided. They are usually of no concern in diagnosis, exceptions noted, if the examining surgeon is active. They sometimes do not show a fracture, even when present, to the most experienced surgeon, or roentgenologist; the movement to the patient is often harmful at a time when immediate shock treatment and quiet is essential. For matter of records—insurance records, medicolegal safeguards, and at times when a diagnosis is questionable x-rays are necessary. However, it is a good habit to have all fractured, or suspected fractured, skulls x-rayed before leaving your care. Do this either reasonably early to assist a doubtful diagnosis, or late for record reasons. Also, when the injuries to the brain are apparently insignificant at the time, and make no impression on the family, but you suspect, or fear, later cerebral developments, an x-ray showing a "fractured skull" is of great aid in allowing us to hospitalize and carefully study the case. Meningitis from a compound basal fracture, but with few and slight initial symptoms, can, and has, developed as late as the 38th day after injury.

This discussion, while apparently lengthy, is very short for such an important and increasingly common injury. Many points can and should be mentioned and enlarged upon, but I have attempted to present the salient points of must's, do's, and dont's, as I see them in clinical practice.

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CHARACTER IN MEDICINE

In commemoration of the one hundredth anniversary of the founding of Tulane Medical School, the Class of 1934 dedicated their invitation booklet to Dr. Rudolph Matas. On the front page of this booklet, from the pen of this grand old man, comes the finest bit of advice ever offered to the young physician. Written to those aspiring to be surgeons it is nevertheless applicable to every branch of medicine. The editors of the Florida Medical Journal, believing that this short article will be an inspiration to every member of the profession, are pleased to quote verbatim.

"As an old teacher and practitioner of Surgery, I am often asked by young men who are aspiring to be Surgeons: 'What are the qualifications that make for a good Surgeon?' I invariably answer that a man must first possess knowledge, and then a surgical conscience. By a surgical conscience we mean not merely the consciousness of what is wrong with our technics or the procedures and methods that we apply in our operations, but with the morals that guide them. The surgical conscience is the fruit of knowledge, training and long culture in the Science and Art of Surgery and, in a purely technical sense, can be developed and highly cultivated.

"But the moral conscience is that intangible something, 'the still, small voice' that rising from the depths of our innermost selves, whispers its warnings when we are going wrong. It is the spirit of ancestral generations which, whether good or bad, is housed in us while in transit to our successors. Conscience is therefore an inheritance; and the seed of good or evil is implanted in us with our birth. Like other seeds, it will thrive when well cultivated, or it may shrivel and perish when planted in sterile soil. It is therefore influenced, for better or for worse, by the conditions and laws of its environment. The majority of those born of normal, healthy, honest and decent parents have the right seed sown in them when they are born. But conscience is erratic. Some people it misses altogether. They are born without the spark that brings it into existence. In others it is so small and atrophied that it becomes, like the appendix, a useless and dangerous nuisance which we might as well cut out altogether. Some people who have it, listen to it; others, if they do have it, continue to sleep and let it ring itself out—as they would an annoying alarm clock. Others are awakened and promptly get up, and set to work making things right with themselves. When a man wakens to the ring of his conscience, gets to work and starts to put his house in order, we say, he has CHARACTER. Now character is the will to put into action what the voice of conscience has roused in him. Conscience without will to act upon its bidding is powerless and might as well be dead. But the harmonious combination of the two makes the right minded man. When a man has neither conscience nor character he cannot be a good man, and if he is not a good man he cannot be a good surgeon.

"And no matter how skillfully he may take out appendices, gall bladders, resect stomachs, do hernias and other fine jobs in Surgery, we don't want him and he need not apply for fellowship in our Guild.

"Now, my friends, take these thoughts with you for the year; go down into the Valley with your brothers, and work them out in life."

THE PHYSICIAN'S PAY

In a recent number of the Virginia Medical Monthly, Dr. Beverly R. Tucker uttered a few words regarding the practice of medicine, striking a chord which immediately finds a response in the breast of many of us.

"The physician is the best paid man in the world. He is required to have an education which will be a benefit and a comfort to him all the days of his life. He wins a degree and attains the honorable title of doctor. He learns to know more intimately his fellow man than

anyone else can know his fellow. He gets praise for many things that he does not deserve and providence and disease are blamed for his mistakes. He wins the gratitude of those he serves. His charity work is valuable to his experience. If he is reasonably conscientious and works reasonably hard, he builds a practice that will insure him a good house, office and automobile and enable him to rear and educate a family and to stand the losses of the inevitably foolish investments he makes. If he has taste for invention there are innumerable unknown instruments and improvements awaiting him. If he wishes to discover, the laboratory is ready for him. If he likes research the facilities and libraries are available. If he craves adventure insidious dangers lurk around him and there are ever pioneer fields to enter. In his endeavors his government, his community and his fellow physicians stand ready to aid him. He is an advocate without a jury, a judge without a court, a minister without a surplice, a business man without guile, a farmer whose soil is the human body and whose crops are human health and happiness and he is a laborer without a boss. The physician is the best paid man in the world."

These words breathe an optimism which should strengthen us to meet our trials and labors; should encourage us as we realize how distinctly blessed we are in friends and opportunity; and should challenge us to greater activities in the pursuit of our vocation and its many compensations.

RADIO BROADCAST, 1932-33

The following broadcast was arranged by the Public Relations Committee of the Florida Medical Association and given over station WRUF, Gainesville:

MEDICINE AND URBAN DEVELOPMENT*

HENRY HANSON, M.D.,
Jacksonville

We do not know with certainty what the earliest form of life was but it appears probable that it was a one-celled living thing like an amoeba or a bacterium. The first of these were isolated independent individuals, some of which later grouped themselves in colonies. The transition from the one-celled unit with multiple functions to the many-celled organism in which a division of labor was established is the classical example of "ontogeny is the epitome of phylogeny" (the development of the individual is a recapitulation of the development of the race). If we look back into the earliest data on the origin and development of the human race we find a natural inclination to congregate, probably in response to a social instinct as well as for protection. In the wild regions such as the jungles of Africa and portions of South America we find examples of congregation among monkeys, apes and other animals traveling in groups. These move from place to place as the food supply is used up.

Among human beings the family is the first example of grouping. In the earliest stages of the human race when the male chose his mate and the family increased we see the early stages of tribal development and the need of some temporary resting place, first in the form of the cave or in open country the camp or the compound. From this we pass on to the villages or towns as stages in urban development. The early development of towns and villages was probably first in the form of stockades or forts for the sake of protection against predatory animals as well as for the sake of protection against other groups of human beings who sought to increase their own power by conquering and plundering their neighbors. It is probable that this feature runs parallel with the development of human intelligence. It seems that the first type of man lived almost entirely according to animal instincts quite similar to those which one can now observe among apes and monkeys. How long this stage continued we do not know.

With a gathering of large groups of human beings in more or less compact masses in limited space the frequency of contact brings out new problems of various kinds. Those which most concern us in this discussion pertain to health. It is inevitable that sickness of a transmissable nature should spread from one to another among a group of people who live under conditions which permit frequent and intimate contact. That this was recognized by primitive man is proven by the finding of the medicine man, the witch doctor, etc., (among the native tribes in Africa and the early inhabitants of the western hemisphere).

"Great cities present an epitome of the civilization about them. The city is the efflorescence of a nation's culture."[1] In America and Germany about one half of the population is in cities while

*Broadcast delivered under auspices of Florida Medical Association over Station WRUF, Gainesville, April 16, 1933.

in Great Britain 80% of the people live under urban surroundings.

We do not know for certain when the earliest city was founded. However our records take us back as far as 4000 B.C. (or 5000 or 6000 B.C. at Nippur in Babylonia) when a peaceful people called the Sumerians settled in the valley of the Nile.

There is a big jump from the time of primitive man to the Old Testament, and to the time of Moses who has been referred to as the patriarch of rural sanitation and the father of preventive medicine. The basis of the Mosaic sanitary code was cleanliness. Moses, 3000 years ago, taught temporary isolation.

The first name in Greek preventive medicine is Apollo, the son of Aesculapius (Greek Asklepios).

For protection the cities had walls built around them. But in order to live they had to have government. Hence they created law. They had to have worship and finally they learned that in order to preserve their cities and keep the health of those within, they must try to cure the sick, or as they thought, those with Evil Spirits. Some who were more proficient than others at casting out these Evil Spirits and restoring the afflicted (to health) were called Medicine Men. This was the first medicine. When the people decided that for the good of all within the city walls, those who suffered from loathsome diseases should be carried beyond the city gates, that the water that they and their children drank must be kept clean (and dead things not thrown in it) they were, without knowing it, laying down the first law of (public) health.

Among the ancient peoples there were some up-to-date regulations. The Babylonians, for instance, had a sewerage system and brought their drinking water supply a long distance through open canals. The Sumerians used cesspools. Cyrus the Great obliged all his soldiers to boil the drinking water while on military campaigns.

When Rome had become a great city, the rulers were most careful to obtain a pure water supply for the inhabitants. At one time water was brought through pipes as far as 36 mlies from the city.

But Rome with her magnificent water and sewerage system passed away, and throughout the world huge towns and cities sprang up which had practically no provisions for maintaining or protecting the life of the common people. Benson[2] in his "Life in a Medieval City" says, "The ventilation and hygienic conditions were far from good as may be imagined from the smallness of the houses, the compactness of the city, particularly the parts occupied by the people, and especially of the primitive system of sanitation, which was content to use the front street as a main sewer. (Plagues perpetually harassed the people of medieval times and reduced the population miserably.) No advance was made in sanitation till the Victorian Age, when town sanitation was completely revolutionized and, for the first time, efficiently organized."

That this condition prevailed even in cities in our own country as late as seventy years ago is proved by a glance at the statistics of the time. (Especially in the poorer sections of our cities death stalked almost unchecked.) In the congested parts of New York City typhoid, smallpox, scarlet fever and typhus were ever present. Garbage was allowed to collect in the streets until they became impassable. The city sewers, unconnected with any main line to carry the contents out into the bay, simply emptied under the piers of the Hudson and East Rivers. During 1864-1865 New York had more than 2000 cases of smallpox causing more than 600 deaths. Philadelphia in 1865 had 773 deaths from typhoid fever and 334 from typhus fever. The Southern cities were no better off and frequently experienced frightful epidemics of yellow fever, cholera and typhus.

Today, thanks to medicine and sanitation, life in our towns and cities is immeasurably safer and pleasanter than it was even sixty years ago. Scourges like cholera, yellow fever, typhus and smallpox are practically unknown. (A pure drinking water supply is assured us, therefore we will not have cholera.) Medicine has discovered that the mosquito *Aedes aegypti* carries the virus of yellow fever and the *Anopheles,* the parasite of malaria, therefore by guarding ourselves from the bites of these insects we can escape such fevers. Immunization to smallpox and diphtheria is available to all who want it.

The high infant mortality so common in cities 30 or 40 years ago has been reduced through the application of medical knowledge for improving and safeguarding milk.

Another important step toward the healthy city is the growing understanding of the necessity for keeping vital statistics, the record of births,

deaths and disease incidence. Many times the knowledge of a single case of sickness may prevent what in early days would have started an epidemic. Where cases of the same disease are reported it is frequently possible to trace the source of the trouble, and by isolation and immunization prevent the spread of a disease which threatens hundreds with death. Birth and death statistics are the bookkeeping of life and death.

With the advance of commerce and industry, and the rise of the arts and crafts, there must also be an adequate social understanding of the part medicine has played. As our cities have grown rapidly, or slowly, there went hand in hand with their progress the art of medicine and the science of public health.

The rapid concentration of people in cities has presented and still is presenting a problem both for the medical man and the social worker. The cities are ideal media for the planting and growing of communicable diseases, the control of which requires knowledge, ingenuity and eternal vigilance.

Without medicine and public health our very existence in the cities would be threatened. Medical discoveries paved the way for cleaner, finer cities and helped to develop a healthier race of people. The key to progress for cities lies in the safeguarding of the health of the entire people in order that their personal happiness, and the success of their plans, may reach the ideal.

The medical sciences have been helpful in making life more secure for us, in adding to its average length and at the same time improving its quality for the majority.

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STATE NEWS ITEMS

Dr. and Mrs. J. N. McLane of Pensacola announce the birth of a son, Jesse Newman McLane, Jr., at the Pensacola Hospital on June 7th.

* * *

Dr. Walter G. Miles of Orlando was elected to Fellowship in the American Psychiatric Association during the annual meeting held in New York City, May 27-31.

* * *

Dr. B. A. Burks of Winter Park is in New York doing post-graduate work.

Dr. Lester W. Cunningham of Jacksonville has returned from Cleveland where he attended the American Medical Association, its Radiological Section, the American Radium Society and the American College of Radiology of which he was made a Fellow.

* * *

Dr. P. M. Lewis of Orlando has returned from Rochester, Minnesota, where he underwent treatment at the Mayo Clinic.

* * *

The Jackson Memorial Hospital of Miami was recently approved by the Council on Medical Education of the American Medical Association for the training of residents in medicine and surgery.

* * *

Dr. Carl D. Hoffmann of Orlando has been spending a few weeks at the Mayo Clinic in Rochester, Minnesota and at the Barnes' Hospital in St. Louis.

* * *

Dr. and Mrs. Arthur Walters of Miami Beach are on a two months' trip through the New England states, making Boston their headquarters.

* * *

Dr. C. J. Collins and family of Orlando are spending their vacation in New York.

* * *

Dr. Herrman Harris of Jacksonville has returned from a three weeks' vacation spent in New England. During this time, Dr. Harris attended the graduation of his daughter, Miss Hannah Bessie Harris, at Vassar.

* * *

Dr. Meredith Mallory of Orlando and Dr. F. Clifton Moor of Tallahassee have returned from the meeting of the American Medical Association. They were the Florida delegates to the convention and report a very interesting meeting.

* * *

Dr. J. C. Nowling and family of West Palm Beach have returned from a vacation trip. Dr. Nowling attended the twentieth anniversary meeting of his class at Emory University in Atlanta.

* * *

Dr. Ruth S. Hart of Winter Park is doing post-graduate work at Baltimore and New York.

* * *

Dr. Maximilian Stern of Daytona Beach announces the removal of his office to 223 Ocean Boulevard. Dr. Stern's practice is limited to urology.

The Semi-Annual Meeting of the Central Florida Medical Association was held in Leesburg, June 8. This Association is composed of doctors from the counties of Alachua, Marion, Lake, Hernando and Citrus. The following scientific program was presented:

"Treatment of Chronic Pelvic Infections", Gaston Edwards, Orlando.

"The Use and Abuses of Urinary Antiseptics", Edwin H. Andrews, Gainesville.

The following officers were elected at the business session: President, T. H. Wallis, Ocala; vice-presidents, George A. Dame, Inverness, C. M. Tyre, Eustis, and John E. Maines, Jr., Gainesville; secretary-treasurer, James L. Strange, McIntosh. A motion was passed at this meeting that the doctors of Putnam, Pasco and Levy counties be invited to join the association.

The next meeting of the Central Florida Medical Association will be held in Ocala in October.

FOR SALE—Spencer microscope, new Fisher coagulating outfit (complete), tonsil suction outfit, Baumanometer blood-pressure outfit, Cameron diagnostic outfit, illuminated ear speculum set with throat attachment, operating tables; also list surgical instruments, instrument cabinet, etc., all in good condition, some new. Offered at very reasonable prices, either separate or as whole, by widow. Mrs. H. Mercer Richards, Lakeland.

COMPONENT COUNTY SOCIETIES

BROWARD COUNTY MEDICAL SOCIETY

At the regular meeting of the Broward County Medical Society held in Ft. Lauderdale on June 27, 1934, the following action was taken:

A resolution was adopted which is a verbatim copy of the resolution adopted by the Duval County Medical Society with regard to the Medical Practice Act of the State of Florida, a copy of which all secretaries of component societies have in their files.

The Broward County Medical Society also respectfully suggests the following: that each local society appoint a Legislative Committee to contact local representatives in the State Legislature and get them in the proper frame of mind to vote for such a bill as the Florida Medical Association may submit to the coming Legislature.

The Society suggests to the Legislative Committee of the State Medical Association that due cognizance be taken of the resolution presented by the Economics Committee of the Association which was adopted by the House of Delegates at the last annual meeting in Jacksonville in framing the new laws.

DADE COUNTY MEDICAL SOCIETY

At the regular meeting of the Dade County Medical Society, held in the Huntington Club Rooms, July 6th, the following program was given:

"Hobbies", M. P. DeBoe, Miami.

"Agranulocytosis (Preliminary Report for the Treatment of Neutropenia with Yellow Bone Marrow)", M. Jay Flipse, Miami.

DUVAL COUNTY MEDICAL SOCIETY

The last meeting of the summer was held by the Duval County Medical Society, June 5th at the Mayflower Hotel, Jacksonville. The scientific program consisted of a symposium on "The Urinary Tract in Infancy and Childhood", as follows:

"Instruments: Cystoscopes and Catheters", E. T. Sellers.

"Cystoscopy and Pyelography", Robert B. McIver and William M. Shaw.

"Case Demonstrations: The Hematurias", Luther W. Holloway.

ORANGE COUNTY MEDICAL SOCIETY

The second annual picnic of the Orange County Medical Society was held at Lakeside Park, south of Orlando, June 30th. Although the crowd collected slowly, by the time the barbecue was served, some seventy-five members of the Association were present, coming from as far as Pensacola and Miami. From the standpoint of the State Association, the picnic was an asset as it brought so many men together, renewing friendships and medical and political contacts. It also afforded an opportunity for many of the state association committees—the executive, the cancer control, public relations and council—to hold meetings which were profitable.

The quantity of Brunswick stew consumed shows that it still possesses a place in the menu of all barbecue picnics.

Following the dinner, the president called a meeting of what he termed his cabinet, *i.e.*, the chairmen of the various committees, the president-elect, the secretary, and the business manager. This was one of the best group meetings held this year.

The Orange County Medical Society feels amply repaid for the effort and expense of the picnic and look forward to a similar meeting next year with increased attendance.

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PASCO-HERNANDO-CITRUS COUNTY MEDICAL SOCIETY

Dr. George and Dr. Leland Dame entertained the Pasco-Hernando-Citrus County Medical Society at Inverness Friday night, June 15th. A full course duck dinner was served at the cafe, followed by a meeting in office of Drs. George and Leland Dame.

The Society was honored at this meeting by having the members of the Marion County Medical Society as its guests, and express appreciation to Drs. George and Leland Dame for arranging this nice entertainment.

Dr. Hudson, president, turned the meeting over to Dr. George Dame, who conducted the program.

Dr. H. C. Dozier, of Ocala, read a very interesting paper on "Cancer Problems—The Responsibility of the Laity."

Dr. R. D. Ferguson, of Ocala, read a paper on "Aneurysm" and showed pathology specimen of this case.

Dr. R. E. Russell, of Ocala, gave a very interesting talk on "Glaucoma" with signs and symptoms and diagnosis.

Other doctors present gave interesting talks.

An invitation was extended to the members of the Pasco-Hernando-Citrus County Medical Society to meet with the Central Florida Medical Society, in Ocala at their next meeting in October.

Guests present: Dr. J. L. Chalker, Dr. R. C. Cummings, Dr. H. C. Dozier, Dr. R. D. Ferguson, Dr. J. N. Moore, Dr. R. E. Russell, Dr. Eugene Peek and Dr. H .F. Watts, all of Ocala.

PUTNAM COUNTY MEDICAL SOCIETY

THE PUTNAM COUNTY MEDICAL SOCIETY HAS JOINED THE EVER-GROWING LIST OF SOCIETIES WITH 100% OF MEMBERSHIP DUES PAID FOR 1934. THIS SOCIETY IS HEADED BY DR. A. E. DREXEL AS PRESIDENT AND DR. E. W. WARREN, SECRETARY-TREASURER.

SUMTER COUNTY MEDICAL SOCIETY

100% MEMBERSHIP DUES HAVE BEEN RECEIVED FOR 1934 FROM THE SUMTER COUNTY MEDICAL SOCIETY. ALTHOUGH THIS IS ONE OF OUR SMALL SOCIETIES IT IS ONE THAT CAN ALWAYS BE DEPENDED UPON TO COME IN 100%.



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MEDICAL AUXILIARY CLOSES SEASON WITH BEACH BUFFET LUNCHEON

Climaxing a successful season of the Woman's Auxiliary to the Duval County Medical Society, was the buffet luncheon given Thursday, June 8th, in the beach home of Mrs. A. H. Wilkinson, at Neptune. The tables were overlaid with dainty embroidered covers, and the guests were seated informally. The spacious rooms of the lovely home were decorated with artistic arrangements of flowers, which served to add a welcome to the warm and gracious gesture of the hostess.

The business meeting which followed the luncheon, was presided over by Mrs. Gordon Ira, and opened with the club woman's prayer, which was read by Mrs. E. W. Veal.

The annual reports of officers and committee chairmen revealed a great increase in the activities of the auxiliary during the past year. A rising vote of thanks was given Mrs. Frederick J. Waas, social chairman, for her untiring efforts in arranging such a lovely program of entertainment features for the State Medical Auxiliary, which convened in Jacksonville April 30 and May 1 and 2. Special mention was given to the annual report of the program chairman, Mrs. A. K. Wilson, and the fine way in which she conducted the programs. A rising vote of thanks was given the president, Mrs. Gordon Ira, for her work.

A discussion followed as to the next year's work. Mrs. Theodore Croft made a motion, which was seconded by Mrs. Luther Holloway, that the auxiliary give a picnic for the entertain-



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ment of the members and their husbands in July. Mrs. William Kirk made a motion seconded by Mrs. Theodore Croft, that the auxiliary "wipe the slate clean as to back dues." The president announced that dues for next year are payable the first Thursday in October, at which time the meeting of the organization will be held in the home of Mrs. O. P. Broadbent.

The following officers were elected: Mrs. Gordon Ira, president; Mrs. A. K. Wilson, vice-president; Mrs. O. P. Broadbent, secretary; and Mrs. Edward Jelks, treasurer.

Attending the luncheon were Mrs. Gordon Ira, Mrs. A. K. Wilson, Mrs. O. P. Broadbent, Mrs. Edward Jelks, Mrs. Ella K. Martin, Mrs. John H. Mitchell, Mrs. L. Y. Dyrenforth, Mrs. E. W. Veal, Mrs. L. W. Holloway, Mrs. Theodore Croft, Mrs. Ernest B. Milam, Mrs. Frederick J. Waas, Mrs. J. L. Kirby-Smith, Mrs. William W. Kirk, Mrs. Paul Eaton, Mrs. F. A. Brink, Mrs. J. S. Critchfield, Mrs. C. W. Johnston, Mrs. George Richardson, Mrs. Clarence D. Rollins, Mrs. F. W. Krueger, Mrs. A. B. Chapman, Mrs. F. C. Keisling, Mrs. J. H. Owens, Mrs. Clayton E. Royce, Mrs. A. B. Quasser, Mrs. A. H. Wilkinson, Mrs. S. M. Copeland, Mrs. C. C. Collins, Mrs. W. G. Harris, Mrs. Robert M. Baker and Mrs. Banks H. Goodale.

* * *

Marion County Auxiliary joined the Marion County Medical Society for a social meeting June 21st, held at the summer home of Dr. and Mrs. J. N. Moore, on the north shore of beautiful Lake Weir. Swimming, rowing and fishing were enjoyed until late evening when a bountiful covered-dish supper was served. The next auxiliary meeting will be held early in July in Dunnellon, when Mrs. Abner Brown will be luncheon hostess after which the auxiliary will disband until early fall.

* * *

News Items From Pennsylvania

Since there is a scarcity of news from the Auxiliaries in our own State as this article goes to press we would have you gain inspiration from the following notes on philanthropy in Pennsylvania. These items constitute an inspiring record. Surely if we use it as a basis of judgment we are convinced that William Penn's old loyalty to the principle of "Brotherly Love" is still alive in the state named for him.

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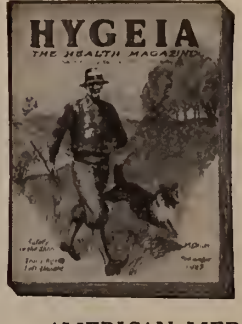
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The Auxiliary to the Erie County Medical Society held a bridge tea in February for more than 200 guests. The proceeds supplied thirteen pairs of glasses for some deserving poor children. The chief compensation from the effort expended by the loyal workers comes from the thought of those children who will have their vision restored to normal or near normal through the generosity of the auxiliary and its friends.

The Franklin County Auxiliary donated 500 second hand books to the Mont Alto Sanatorium during the past year.

Lackawanna County conducted a style show with auxiliary members as models for the benefit of the Medical Benevolent Fund.

Lehigh County held a Valentine party and sponsored a motion picture show, the proceeds of both ventures being added to the charity fund.

Lycoming County made a donation of $300.00 towards a deep therapy machine for the Williamsport Hospital.

Montgomery County held a card party in April and earned money for the Medical Benevolent Fund.

The Montour County Auxiliary has been cooperating during the year with the State nurse in furnishing needed layettes. The material is supplied by the auxiliary and the work is done by the members of that body. The members have also been acting as chauffeurs in bringing children from outlying districts to the Clinic for treatment.

In Philadelphia the financial statement shows that $1149.22 has been raised by the Ways and Means Committee during the year. This is exclusive of dues and will be used for various forms of medical welfare. $826.00 of this amount has been given to the Aid Association of the Philadelphia County Medical Society, the United Campaign, Red Cross, milk for undernourished children and other benevolences. In addition the group is also constantly at work for the Medical Benevolence Fund.

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SCHEDULE OF MEETINGS—COMPONENT SOCIETIES FLORIDA MEDICAL ASSOCIATION

COUNTY SOCIETY	SECRETARY	MEETINGS				Dues Paid.
		Date	Time	Place	Luncheon?	
Alachua	Harry M. Merchant, M.D., Gainesville.	2nd Tuesday	12:00 Noon	White House Gainesville	Yes.	86%
Bay	Allen H. Miller, M.D., Millville.					71%
Brevard	L. K. Hicks, M.D., Melbourne.	2nd Tuesday		Varies	Yes.	56%
Broward	O. C. Brown, M.D., Ft. Laudardale.	Last Wednesday.	8:00 P.M.	Elks' Hall Ft. Lauderdale	No.	94%
Columbia	T. H. Bates, M.D., Lake City.	1st Monday	7:30 P.M.	Blanche Hotel Lake City		100%
Dade	Robert T. Spicer, M.D., Miami.	1st Friday	8:30 P.M.	Club Room Huntington Bldg. Miami	Occasionally.	92%
DeSoto-Hardee-Highlands	L. W. Martin, M.D., Sebring.	2nd Tuesday	8:00 P.M.	Varies	Yes.	93%
Duval	B. F. Woolsey, M.D., Jacksonville.	1st Tuesday	8:15 P.M.	Mayflower Hotel Jacksonville	No.	80%
Escambia	J. M. Hoffman, M.D., Pensacola.	2nd Tuesday	8:00 P.M.	Board of Health Building Pensacola	No.	68%
Hillsboro	John S. Helms, Jr., M.D., Tampa.	1st Tuesday	8:00 P.M.	Tampa Municipal Hospital Tampa	No.	100%
Jackson	Lewis Pierce, M.D., Marianna.	2nd Tuesday	7:30 P.M.	Hotel Chipola, Marianna	Yes.	91%
Lake	W. L. Ashton, M.D., Umatilla.	1st Thursday	12:30 P.M.	Eustis	Yes.	94%
Lee	Robley D. Newton, M.D., Ft. Myers.	3rd Friday	7:30 P.M.	Lee Memorial Hospital Ft. Myers	No.	100%
Leon-Gadsden-Liberty-Wakulla-Jefferson	O. G. Kendrick, M.D., Tallahassee.	Quarterly	3:00 P.M.	Varies	Yes.	96%
Madison	Geo. O. Davis, M.D., Madison.					100%
Manatee	W. D. Sugg, M.D., Bradenton.	3rd Tuesday	7:00 P.M.	Whitfield Country Club Bradenton	Yes.	100%
Marion	Richard C. Cumming, M.D., Ocala.	3rd Thursday	12:30 P.M.	Marion Hotel Ocala	Yes.	95%
Monroe	W. R. Warren, M.D., Key West.	1st Sunday	9:00 P.M.	Varies	Yes.	100%
Orange	John A. Pines, M.D., Orlando.	3rd Wednesday	8:30 P.M.	Varies	No.	100%
Palm Beach	R. Henry Baldwin, M.D., W. Palm Beach.	4th Monday	8:00 P.M.	Good Samaritan Hospital W. Palm Beach	No.	100%
Pasco-Hernando-Citrus	Geo. R. Creekmore, M.D., Brooksville.	2nd Thursday	7:00 P.M.	Varies	Yes.	100%
Pinellas	O. O. Feaster, M.D., St. Petersburg	1st Friday	8:00 P.M.	Assembly Room, 5th floor, P. & L. Bldg. St. Petersburg	No.	100%
Polk	J. R. Boulware, Jr., M.D., Lakeland.	2nd Wednesday in Feb., Apr., June, Aug., Oct., Dec.	1:00 P.M.	Lakeland	Yes.	94%
Putnam	E. W. Warren, M.D., Palatka.	2nd Thursday	7:00 P.M.	James Hotel, Palatka	Yes.	100%
St. Johns	Reddin Britt, M.D., St. Augustine.	3rd Tuesday	8:30 P.M.	Varies	Yes.	100%
St. Lucie-Okeechobee-Indian River-Martin	J. D. Parker, M.D., Stuart.	3rd Thursday	8:00 P.M.	Varies	Yes.	92%
Sarasota	J. E. Harris, M.D., Sarasota.	2nd Tuesday	8:30 P.M.	Varies	Occasionally.	100%
Seminole	J. T. Denton, M.D., Sanford.	2nd Monday	7:00 P.M.	City Hospital Sanford	Yes.	100%
Sumter	W. E. Mitchell, M.D., Coleman.	2nd Tuesday		Varies	No.	100%
Taylor	C. A. O'Quinn, M.D., Perry.	Last Friday	8:00 P.M.	Dixie-Taylor Hotel Perry	Yes.	100%
Volusia	Joseph H. Rutter, M.D., Daytona Beach.	2nd Tuesday	7:30 P.M.	Varies	Yes.	97%
Walton-Okaloosa	A. G. Williams, M.D., Lakewood.	3rd Thursday	8:00 P.M.	Varies	Occasionally.	100%

NOTE—Secretaries: Please submit information to complete the above schedule.

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THE JOURNAL
— OF THE —
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NO. 2

Jacksonville, Florida, August, 1934

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THE N. Y. ACADEMY OF MEDICINE
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NEXT SESSIONS Florida Medical Association, Ocala, 1935.
Southern Medical Association, San Antonio, November 13-16, 1934.

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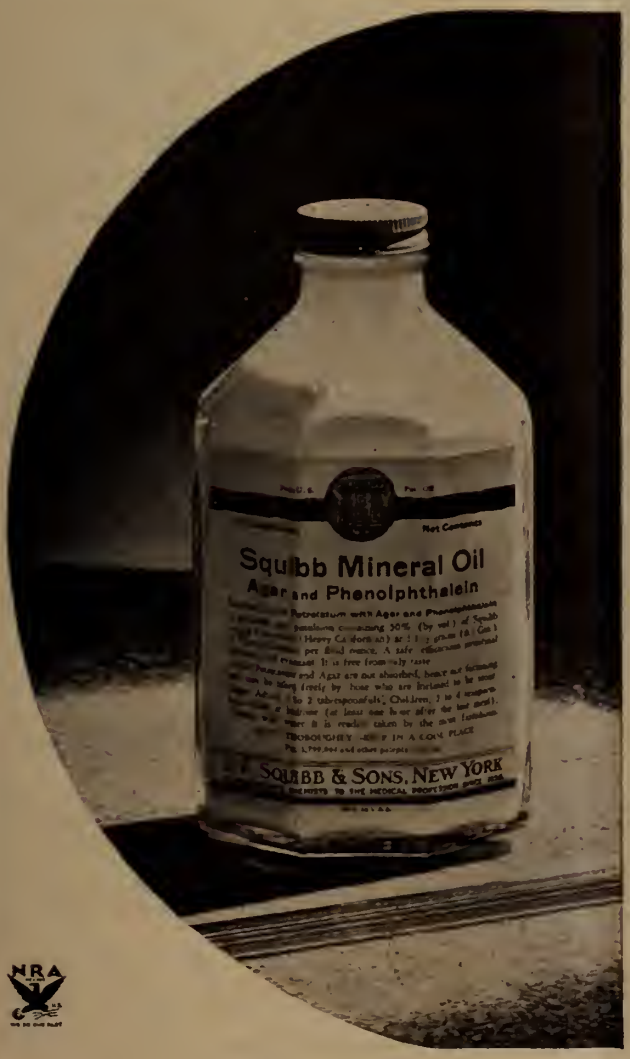
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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
PUBLISHED MONTHLY

Volume XXI | Jacksonville, Florida, August, 1934 | Number 2

ARTHRITIS*

JULIAN E. GAMMON, M.D.,
Jacksonville.

My subject today is arthritis and within the limited time of fifteen minutes I want to give you as clear a concept of the disease arthritis, as I know it, in its various ramifications.

Two years ago I read a paper before this Association under the caption of Chronic Infectious Arthritis and presented an etiological classification of arthritis. The article was published in the Florida Medical Journal. A year later, the heads of the arthritic clinics met in New York and adopted a similar classification.

From an etiological viewpoint there are five important factors responsible for the various types of arthritis, viz: (1) bacterial infections, (2) metabolic dysfunction, (3) allergy or hypersensitiveness of the joint to bacterial allergens and to foreign sera, (4) trauma, (5) neuropathic disturbances. Each etiological factor is represented by a distinct type of arthritis but as a rule more than one of these factors play a part in causing each type of the disease. For instance, in the infectious group bacterial allergic reactions are important in producing the disease, while in the metabolic group allergy and infection play no part. Trauma, especially in the weight bearing joints, is a factor in both, but to a greater degree in the metabolic group. And while the changes in the joint in the neuropathic group, as Charcot's joint, are due primarily to the neurological lesion, the secondary factors are trauma and loss of tissue vitality and trophic metabolic dysfunction in the joint, and the pathological picture is similar to osteoarthritis.

Now, I want to give you a classification which I think will be very helpful in diagnosis and in directing rational therapy. The classification in detail is as follows:

*Read before the Sixty-first Annual Meeting of the Florida Medical Association, Jacksonville, April 30, May 1 and 2, 1934.

CLASSIFICATION OF ARTHRITIS

I. Infectious—	(A) Focal infections 1 streptococci and occasionally staphylococci	
	(A) Secondary infection 2 streptococci in lesion of hollow viscera draining into adjacent lymph glands	(1) Chronic infectious arthritis Syn- Rheumatoid arthritis Atrophic arthritis deformans Proliferative arthritis Still's disease in childhood
	(B) Specific organisms	(1) Gonorrheal arthritis (2) Syphilitic arthritis (3) Tuberculous arthritis (4) Arthritis caused by other specific organisms
	(C) Complicating sepsis, wounds	(1) Septic arthritis (specify organism)
	(D) Etiology unknown Protean clinical features Frequent heart disease leaving no joint deformity	(1) Rheumatic fever
II. Metabolic—	(A) Dysfunction (purine) (purine or carbohydrate) (metabolic decline in aging process)	(1) Gout (2) Osteoarthritis Syn- Hypertrophic arthritis deformans Degenerative arthritis
	(B) Deficiencies (vitamine) (vitamine and sunshine)	(1) Scurvy (2) Rickets
III. Allergic—	(A) Bacterial allergens	(1) Rheumatic fever (2) Poncet's tuberculous arthritis (3) Some infectious arthritides
	(B) Foreign sera	(1) Serum sickness

IV. Traumatic—(A) Fractures into the joint
(B) Hemorrhage as in hemophilia
(C) Excessive wear and tear in deformed joints, joints of the aged.

V. Neuropathic—(A) Tabes
(B) Syringomyelia
(C) Hemiplegia
(D) Spina bifida
(1) Charcot's joint

It is evident that it will take a course of lectures to go into detail regarding these various groups and subgroups of arthritis, so I am going to limit my remarks to chronic infectious arthritis of focal origin and to some phases of the metabolic group.

In chronic infectious arthritis of focal origin and due particularly to streptococcus hemolyticus, viridans and non-hemolyticus, and very occasionally to staphylococcus albus, the pathological changes begin in the synovial membrane as an allergic reaction in many instances, and in others by direct infection of the joint tissues. The synovial membrane frequently secretes an excess of fluid distending the joint capsule, sometimes to a marked degree. Fringes and villus formations appear and in time a pannus-like layer of granulation tissue extends from the synovial membrane over the articular surfaces causing softening, absorption and erosion of the joint cartilage. The perichondrium proliferates to a variable degree forming specialized connective tissue which may be converted into cartilage or bone. Frequently, the connective tissue of the epiphyseal bone marrow proliferates and granulation tissue extends upward from the subchondrial bone into the cartilage causing destruction and absorption of the cartilage. Thus, the joint cartilage is destroyed in two ways, viz: by the pannus-like growth of granulation tissue from the synovial membrane extending over the joint surface, and by the proliferation of granulation tissue arising in the epiphyseal marrow and extending up into the cartilage from below. Subluxation and luxation are likely to occur when the joint cartilage is destroyed. The endosteum of the epiphysis may also undergo a variable proliferation forming new bone cartilage along the epiphyseal line and true ankylosis may occur in this type of joint.

Now, we have at least one cause, focal infection, and the effect, the pathological change, face to face, and the problem is how can we prevent and how can we cure the disease? The answer is first, by finding and removing the focal infection, and at the same time growing in pure culture the offending organism for future vaccine therapy. This is imperative. Second, by supportive treatment—a treatment similar to the modern treatment of pulmonary tuberculosis, the special features receiving appropriate measures. Third, by desensitizing and immunizing the patient by intradermal injections of the autogenous vaccine over a long period of time. Fourth, by removing diseased tissue as the synovial membrane and the pannus of granulation tissue, which is an outgrowth of the synovial membrane. Fifth, by orthopedic measures as interposing fascia between the joint surfaces.

The problem is not as easy as it sounds for it requires a great deal of study, patience, skill and cooperation in order to get the desired results. And I want to state here that we have no specific drug which will cure the disease. Drugs, if used at all, should be for symptomatic relief.

The time element is all important. In early cases the results are most frequently good, but if treatment is instigated after the vulnerable part of the joint, the joint cartilage, is destroyed or burnt out, so to speak, the results are most often poor, excepting in those patients who in time acquire sufficient immunity to allow the orthopedic surgeon to come to the rescue with reparative measures which frequently restore the function of the joint in some degree.

The first step in treatment is to find and remove the primary focus of infection and grow in pure culture the offending organism and make the autogenous vaccine by proper methods for vaccine therapy. I want to emphasize here that these two procedures are not properly coordinated in most patients with arthritis. The removal of the primary focus is not easily done, the organism has spread to other tissues, particularly the lymph glands, and the disease goes on. Dental focal infection can be eradicated completely and the results are sometimes striking, relief prompt or within a few months. There are other patients who will not improve without the use of the autogenous vaccine over a prolonged period. I haven't much faith in the nonspecific therapy of arthritis, as, milk, stock vac-

cines, etc., excepting in gonorrhea where the organism is known and only after the primary disease in the urethra, prostate, tubes, etc., has been clinically cured. In general I may say that vaccine therapy is of no value in the treatment of acute infectious diseases and it holds true in arthritis.

Now, I want to divert your attention to the second great group of arthritides, the metabolic group, and take up first, gout, as a factor causing arthritis. We know the disease is due to dysfunction in the purine metabolism and the clinical symptoms may be controlled by a low purine diet, and colchicum during the acute attacks. Uric acid, which is an end product of nucleic acid metabolism, is deposited in the soft tissues causing an acute inflammatory reaction, and further, uric acid or the sodium salt is deposited in the joints of the extremities particularly, as a chalky layer over the cartilage causing absorption and erosion. Uric acid is also deposited in the cartilage and even in the bone. When the uric acid is absorbed the calcium salts are usually absorbed also, leaving punched-out areas on the joint margin and cystic-like areas in the medulla of the bone. The periosteum at the joint margin is converted into bone, thus completing the bony ringlet at the joint margin. The periosteum at the insertion of tendons may be converted into bone, producing bony prominences and spurs in these regions. Outspoken clinical gout is not such a frequent disease, nowadays, and I bring the subject up only to throw more light on the next disease, osteoarthritis.

In osteoarthritis the pathological process begins in the joint cartilage. There is vertical fibrillation, softening and erosion of the cartilagenous surface in areas of variable sizes and the perichondrum of the opposite cartilage proliferates and fills in the dead space or eroded area, thus keeping the joint surfaces in contact. This process goes on very slowly and at times even without symptoms, and there is also a gradual thinning of the joint cartilage. The joint line becomes very irregular from the erosions and perichondrial proliferations on opposite surfaces and motion may be very limited. In time the joint cartilage may be destroyed on both surfaces and the uncovered bone becomes very dense, even more dense than cortical bone in some instances. The two opposing surfaces of dense bone do not form a true bony ankylosis, although motion at times may be very limited due to the irregularities in the joint line and to bony deposits at the joint margins. There is lipping or mushrooming at the joint margins; cyst-like formations appear in the medulla of the subchondrial bone; the periosteum is converted into bone at the tendon insertions producing spurs and ridges so often seen in x-ray films. Quite extensive destruction of the cartilage may occur, however, before the x-ray film reveals what is taking place—thinning of the joint space being the only clue. Again, there is marked thinning of the joint space and marked lipping without symptoms, and the question naturally arises: What is the toxic substance causing the destruction and what is the activating agent?

Certainly, the pathological picture of osteoarthritis cannot be due to a degenerative process alone for it frequently begins in the thirties, if not before, its frequency increasing with age, and we know there is a gradual basal metabolic decline in proportion to increasing age. Neither can trauma be the activating agent for women who live in luxury and are never subjected to trauma have the disease. Studies in metabolism in these patients are throwing light upon the subject, as many of the osteoarthritic patients have an abnormal purine response or a low carbohydrate tolerance or both. Many are over-weight and some have a lowered basal metabolism. The most encouraging thing is that if these patients are taken in hand early and the proper metabolic corrections made the clinical course of the disease can be controlled. Those who have an abnormal purine response are put on a low purine diet, and those with a low carbohydrate tolerance are put on a sugar-free and low starch diet. The obese are reduced to normal weight and when the basal metabolic rate is below the normal standard for the age thyroid gland should be given in proper amounts. Thus, the clinical symptoms of the disease may be controlled in osteoarthritis but the bony lipping and spurs are permanent.

In conclusion, great headway has been made in the classification and the treatment of arthritis and I want to urge you as practitioners not to wait till the joint bearings are burnt out and recovery all but impossible. Have the patient investigated early and adopt the modern plan of therapy and the results will be gratifying.

DISCUSSION

Dr. W. McL. Shaw, Jacksonville:

I will not go into any classification of arthritis. Dr. Gammon has brought out the confusion that already exists in trying to classify it. But, from the roentgenologist's point of view the best way to present it is by an etiological classification. I wish to show a few films illustrating several of the types of which Dr. Gammon spoke.

We have four tissues involved in the formation of each joint, namely, synovial fluid, synovial membrane, cartilage and ligaments. Bone does not primarily enter into the formation of a joint. We have destruction or disease of one or more of these four structures in every arthritis.

FILMS:

I. *Metabolic Dysfunction:*

The first film is one of gout, representing metabolic dysfunction. In gout the characteristic findings are these punched-out or decalcified areas that appear as holes, as Dr. Gammon described.

This film also demonstrates another type of arthritis, an old gunshot wound of twenty years' standing with traumatic arthritis resulting in bone against bone without any cartilage.

The gouty joint has swollen periosteal structures, and cartilage thinned out. It is due to these periosteal changes in the bone that you get the characteristic punched-out walls back of the joint line.

Another film in this same group shows the so-called hypertrophic arthritis. Inflammation is particularly irregular with spur formation. You never get a bony ankylosis in arthritis of this nature. In this form the gastro-intestinal tract is particularly at fault. These are the cases greatly relieved at times with colonic irrigations.

II. *Neuropathic Arthritis:*

The next film is of the neuropathic type. Here is a Charcot joint of the elbow with complete destruction of the cartilage back into the bone and thickening of the adjacent bone. This lateral view shows complete joint destruction.

Another case of Charcot joint of the ankle: The patient walked in on this ankle. It was not painful, but rather noisy. You could hear it grate. There was complete destruction of the ankle joint structure, bone against bone, with a jagged saw-tooth effect that Dr. Gammon described as "jig-saw puzzle" effect. There is a peculiar loss of pain in these Charcot joints.

III. *Bacterial Infections:*

One of the largest groups of arthritis we have to deal with is bacterial infections. This film is an old gonococcus arthritis from gonorrhea of sixteen years' standing. The point I wish to demonstrate is that the joint has just been rubbed out on the film as in icing on a cake. You get the effect of a thin layer of bone spread over the joint. The sacro-iliacs are obliterated. This condition runs up to the cervical area in this case.

This film shows an acute gonorrheal infection of the elbow. Here we get "a burning out" of the bearings, as has been expressed. This is the acute stage. The articular surfaces are going and the bone is getting ready to throw out new bone and close the entire joint.

Another of the larger groups we have to deal with outside of the gonococcus infections, is general bacterial infection. This film is of a streptococcic joint which presents practically the same picture with a jagged saw-tooth effect. The cartilage is "burned out" and clusters of spur formations form in the joint.

The next film shows a staphylococcic joint. This is an osteomyelitis including the os calcis, the ankle joint and the lower end of the tibia. This is another film of the same joint with lipiodol injection showing a sinus tract leading entirely through the joint with destruction of all articular surfaces and resulting osteomyelitis of the tibia and fibula. This is practically the same picture as streptococcic osteomyelitis with fixation of the joint and marked atrophy in the tarsal bones.

IV. *Traumatic Arthritis:*

The traumatic arthritides I will not show. We get them in workmen who stand all day on a hard cement floor with constant injury to the knee joint. There are no characteristic x-ray changes.

V. *Allergic Joints:*

Allergies I am not going to show because the x-ray does not show any joint change in these allergic conditions. Such joints will look practically normal on the illuminator. We find them frequently following administration of horse serum, etc.

Dr. Clayton E. Royce, Jacksonville:

I think it is quite apparent to any one who has done only casual and but little reading on the

subject of arthritis that there are many varied concepts of the disease, that there are many varied results while using the same technique in the study and treatment of the disease.

Nevertheless, I feel that in the paper which Dr. Gammon has presented this morning, he has given you a comprehensive survey of the entire subject. He has covered every particular point that there is to be covered in a general way. My discussion of the paper will be limited to personal experiences with studying the bacteriology of this joint condition.

I also want to emphasize particularly some things which Dr. Gammon did not bring out in his paper for lack of time. One of them he touched on first of all, and that is never to have a focus of infection removed without first making preparations to have a culture made from that focus of infection. Because many cases have gone on into a long-continued chronic stage when that might have been prevented by the benefits of vaccine procured from a culture made when the primary focus was removed. After the primary focus is removed, that much is lost. Time is lost, and perhaps the entire opportunity is lost. Making these cultures is not as simple a matter as it might sound to be. It is simple enough to get everything ready in the first place, but it requires very close cooperation between the man who is going to remove the focus, the technician and the bacteriologist. The bacteriologist must be there when the focus is removed with culture media ready to receive the material directly from the man who has removed it. Whether teeth or tonsils or whatever it may be, it needs to go at once into the proper culture media. And the culture media should be previously warmed to body temperature so that there is no opportunity for a change in temperature to affect these organisms. The organisms which produce chronic arthritis are sensitive organisms, especially susceptible to sudden changes. Many of these, especially those about the roots of the teeth, are accustomed to living with low oxygen pressure and it is necessary to provide a media which will take care of that. Get it into culture directly and results should follow.

Sometimes people ask, how do you know that you have a streptococcus that is making the trouble, from the teeth for instance? The answer is: If you get some of the streptococci from the mouth that will grow on any kind of culture media, or if you get the one making the trouble that grows slowly at first or won't grow at all in ordinary culture media until placed in culture media which is especially adapted to it.

The method of Dr. Meyer Solis-Cohen of Philadelphia is very useful, particularly when culture is made from diseased tonsils. He puts a little septic material into a dry culture tube and adds a few cubic cm. of blood from the patient's vein to this material. You would very often be surprised at the results that follow. As a rule in the patient's blood only one kind will grow out and that is presumed to be the kind against which the patient has no defense.

We have come to the belief in working on these cases that the organism is type specific. That is, you must use vaccine made from the organism from the patient. Excepting in cases of gonococcus, stock vaccine has not proved of value.

That is not the experience of every one who has worked on the tests, but as I say we can only report what we have found out.

Dr. Julian E. Gammon, Jacksonville (concluding):

The subject arthritis is a large one. A classification has been presented and some phases of the subject discussed.

I want to emphasize one thing further about the infectious group of arthritis and that is: we have no specific drug that will cure the disease, neither have we a specific antitoxin. We must find the focus of infection, do our utmost to remove it, although the difficulties are great at times; make autogenous vaccines for future desensitization and immunity. We must support the patient with adequate measures during the course of immunization and finally in some selected cases remove diseased tissue and apply other orthopedic measures when indicated.

The second great group of arthritis, called osteoarthritis or hypertrophic arthritis deformans, is not due to infection. The disease begins in the cartilage and is most frequently due to a metabolic disturbance. Its frequency increases with the aging process, which shows a gradual metabolic decline. Some forms of this type of arthritis are due to trauma.

And so, we have the two great groups of arthritis due to entirely different etiological processes, the one beginning in the synovial membranes and the other in the cartilage.

QUININE AND MALARIA*

PAUL EATON, M.D.,
Jacksonville.

Although it has been known for a long time that quinine is a specific for malaria, there is no substantial agreement as to how it acts. Malaria plasmodia will swim about gay and unharmed in concentrations of quinine far greater than can ever be obtained in the blood in practice. Stimulation of phagocytosis is alleged by some to be the modus operandi. The best explanation offered so far is that the animal body is able to elaborate out of quinine, a substance harmless to itself, yet toxic for the parasite. This is equivalent to saying that the drug cures the disease.

As far as I can determine, published reports of experimental work along this line are limited to statements that malaria plasmodia, known to have been in the patient's blood, were, or were not, discoverable in the blood after the administration of such and such amounts of such and such salts of quinine.

In this paper I desire to present a method of study rather than any important results.

The method I propose is based on the fact that the age-group characteristics of any population constitute a very important source of information as to the state or condition of said population. It is universally acknowledged that this is true with respect to human populations. Damren and I showed that this feature could be profitably used in determining the life duration of the red cell. I now propose to apply the same idea to the study of the parasite population in the blood in cases of malaria.

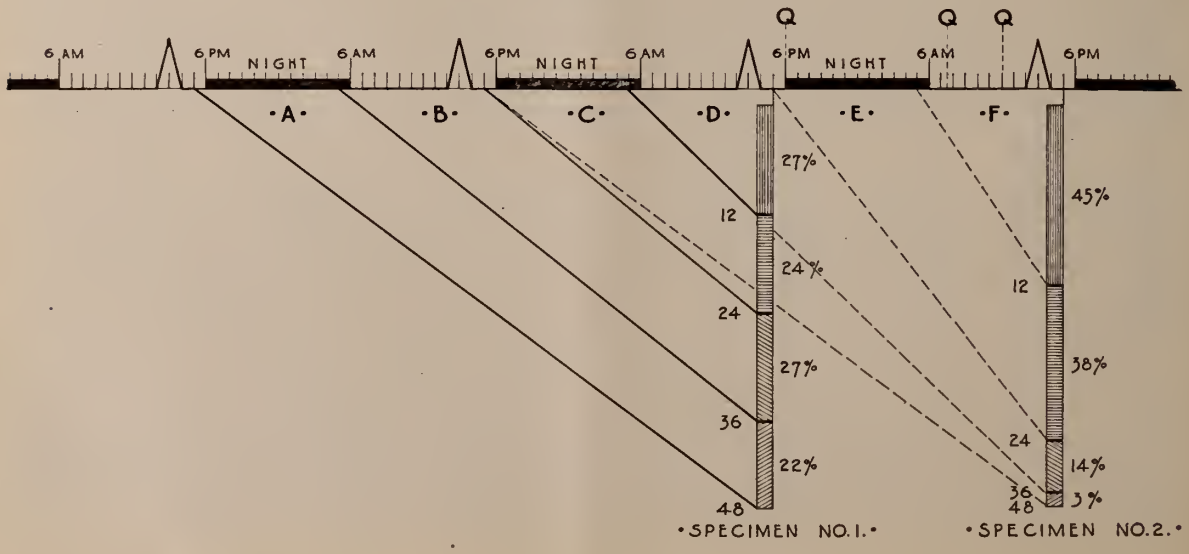
It is, of course, impossible to tell the age of a malaria parasite to the hour, merely by looking at it; but with the knowledge we have it is quite possible to make a rough classification of P. vivax for example into twelve hour age groups, and if a sufficient number be dealt with,we will be justified in believing that errors will balance each other. By this I mean that for every ten or eleven hour old parasite that is erroneously assigned to the second twelve hour period, a thirteen or fourteen hour old parasite will be mistakenly put into the first twelve hour group. This will not be strictly true of course until very large numbers have been dealt with under a very fine technique, but it will be near enough to the truth to give us valuable information.

The application of this method requires careful study of the cases involved and accurate timing of the intervals at which specimens are taken. It may be better understood by considering an example.

N. M., 36, white, mail clerk, who had been showing symptoms of tabes for some time, was infected with P. vivax by the bites of two mosquitoes which immediate dissection showed to have been infected. In the hospital he was allowed to have 18 chills, his temperature crests running from 105.6°F. to 107.0°F. Two hours after the 17th chill a set of blood films was made and quinine was ordered at the rate of 5 grains t.i.d. Twenty-four hours later, immediately after the 18th or last chill, and after the patient had received 15 grains of quinine, another set of films

*Read before the Sixty-first Annual Meeting of the Florida Medical Association, Jacksonville, April 30, May 1 and 2, 1934.

FIGURE 1.



was made. It is to the difference between the parasite populations in these two sets of preparations, that I wish to direct your attention.

Figure 1 shows diagrammatically the relation of the time of taking the blood to the temperature and to the medication.

Since P. vivax lives 48 hours it will be seen that on preparation number 1, there will be parasites referable to period A, B, C, and D. We are interested in the respective numbers or proportions of these. Careful counting revealed the following age-groupings:

TABLE I

Age	%
36-48	3
24-36	27
12-24	24
0-12	27

This table shows first of all that there was in this case a smaller degree of concentration of sporulation at the chill time than the popular belief would lead us to look for. Since the chill was quotidian it is to be expected that the peaks at D and B would be about the same height. There had been a higher mortality among the parasites referable to period A. Ordinary wear and tear and the activities of the white cells might be held to account for this although I do not see just why there should be a difference between A and C and none between B and D.

When we come to consider the preparations made after 15 grains of quinine had been administered we find a totally different picture as in Table II.

TABLE II.

Age	%
36-48	3
24-36	14
12-24	38
0-12	45

This corroborates the finding in preparation number 1 to the effect that there is less concentration of sporulation at chill time than might be expected on the basis of current teachings. But the most important thing is the relative scarcity of parasites more than 24 hours old.

Let it be noted that these findings are purely relative. That is to say, we have no means of knowing from this work how many parasites had been killed. All we do know is that the survivors are distributed into age groups in a way very different from the way in which the original population had been distributed the day before.

These findings need confirmation, but they seem to show that the action of quinine is on the parasites of greatest age.

For help in the tedious task of counting and classifying between five and ten thousand parasitized cells, I wish to express my thanks to Miss Pearl Griffith, Mrs. Janet Bell, Miss Catherine Underwood and Miss Elnor Marr, members of the technical staff of the Jacksonville Laboratory.

DISCUSSION

Dr. Clayton E. Royce, Jacksonville:

In this discussion of Dr. Eaton's I seem to see the opening of the door which will at last put the use of quinine on a scientific basis rather than empirical. In other words I think that if he follows up the work which he has undertaken he will be able to show us just what it is that quinine does to the malarial parasite.

There is a significance in the second group of figures. With only 3% of survivors of the 48 age group, the parasites have been killed off just before sporulation, and for every one of these that is killed off we have avoided the pumping into the blood stream of from twelve to twenty-four new-born parasites—and that little point alone indicates something about the amount of quinine that it is necessary to use.

I happen to know that Dr. Eaton has already made some very successful observations on the age of the red blood cell which is invaded by the parasite, and I am going to take this opportunity to ask Dr. Eaton if he is willing to touch on that phase of the work with regard to the work he has shown us here.

Dr. G. H. Edwards, Orlando:

I would like to ask Dr. Eaton if he gives quinine in the form of pills or solution.

I have for many years given my quinine in solution using a few drops of aromatic sulphuric acid to dissolve it. I have found that most of the pills on the market go through the gastro intestinal tract as pills. Even the famous friable variety is not exempt and many of the tablets which are on the market are also seemingly inert, possibly because, due to illness, a patient is not secreting sufficient hydrochloric acid.

Dr. Paul Eaton, Jacksonville (concluding):

In this case the quinine was given in capsules. I am just as convinced as the questioner that the only way to give quinine is in solution.

PARA-NASAL SINUSITIS*

CORNELIUS G. COAKLEY, M.D.,
New York.

The most common complication of a cold in the head is the infection of some or all of the para-nasal sinuses. These sinuses comprise the two maxillary sinuses, the two groups of ethmoid cells, one on either side, which groups are subdivided into the anterior group and the posterior group of ethmoid cells; the two frontal sinuses and the two sphenoidal sinuses. With the exception of the sphenoidal sinuses the origin and development of them come from cells in the ethmoid labyrinth as a prolongation of these cells into the superior maxillary bone on the one hand, and into the frontal bone on the other. The sphenoidal sinus is not developed from the ethmoid labyrinth, but from a projection back from the posterior portion of the septum. A sphenoidal sinus is not developed before birth and may be present as a pretty good sized cavity during the first few years of life.

It is important to note that by the time a child is born this hollowing out of the superior maxillary bone has already begun, so that the cavity of the maxillary sinus is about the size of a medium-sized pea, but situated high up underneath the orbit. The growth of this cavity is very rapid, and by the time the child reaches the 12th year, it has attained its full development. At birth there are well-defined anterior and posterior ethmoid cells, very small, but still present. On the other hand there is no evidence whatever of an extension up into the frontal region, therefore no frontal sinuses, and these usually do not appear until somewhere about the fifth year of life. This order of development should be borne in mind because young children very frequently have infections of the para-nasal sinuses, and up to the fourth or fifth year when an infection takes place, it consists only of an involvement of the maxillary, ethmoid or sphenoidal sinuses. There is not usually very much difference in the size or capacity of the two maxillary sinuses. There is, however, a very great difference in the size of the ethmoid cells, both the anterior and the posterior group. I have never seen a case where there was an absence of either maxillary sinus or an absence of the ethmoid cells. On the other hand there is an enormous difference in the size and shape of the frontal sinuses. They may both be equal in size but this is rather unusual; one or both of the frontal sinuses may be absent. I think we may account for the nearly uniform development of the maxillary sinuses from the fact that the off-shoot from the ethmoid labyrinth which extends into the superior maxillary bone takes place before the birth of the child, and the growth of this off-shoot is not greatly inhibited by any inflammation of the mucous membrane occurring during the child's life. On the other hand inflammation of the ethmoid cells during infancy interferes with the proper development of the ethmoid labyrinth so that in some patients we may have ethmoid cells that are pretty good sized, and in other cases ethmoid cells that are thick walled and rudimentary in their capacity. It also probably accounts for the fact that there is such great difference in the size, shape and capacity of the frontal sinuses.

If a child has frequent colds during the first three or four years of his life the normal progress of the ethmo-frontal off-shoot is interfered with. It may be complete inhibition in which case there will be no frontal sinus on one or both sides, or it may be inhibition more on one side than the other, thus accounting for the difference in the size of the two frontal sinuses. This inflammatory condition in the ethmoids, limiting the development of the ethmoid cells and the frontal sinus is quite analogous to what takes place in the mastoids. Children with repeated attacks of acute suppurative otitis media, accompanied by some mastoiditis, will be found to have small celled, sclerotic mastoids, whereas those who do not have these acute attacks of ear trouble develop large cells, so-called pneumatic mastoids.

The para-nasal sinuses are lined with a thin layer of mucous membrane not over a twenty-fifth of an inch in thickness. In this mucous membrane there are mucus secreting cells and some serous secreting cells. The epithelial lining is of the columnar ciliated variety. These cilia move particles in a direction towards the normal orifice of the sinus, thus for the maxillary sinus to the middle meatus. In the case of ethmoid cells the anterior group opens in to the middle meatus and the posterior group opens into the superior meatus.

In the case of the frontal sinus the cilia direct the secretion downwards through the naso-frontal canal also into the middle meatus. Normally there is no secretion whatsoever in any of these sinuses, and as we have seen, the sinuses are

*Lecture delivered at First Post-Graduate Medical Course, Gainesville, June 19-24, 1933.

normally free from any bacterial content. It must not be forgotten that the mucous membrane of each of these sinuses is actually a continuation of the mucous membrane of that part of the nose in which the sinus opens, although the structure of the mucous membrane of the sinuses is somewhat different than that of the mucous membrane of the nose proper.

Pathology: Whenever there is an acute inflammation of the nasal mucous membrane, its extension into the para-nasal sinuses must be expected. The extent of this sinus inflammation will depend upon the severity of the inflammation of the nasal mucous membrane, and also upon the effect that the several pathogenic organisms or their toxins may have upon this membrane. During the early stages there is a simple congestion of the mucous membrane and the increased vascularity results in the outpouring at first of a small amount of thin watery albumin containing fluid. If the inflammation becomes more severe in addition to the serum we have an increased activity of the mucus secreting cells so that there is a thick mucoid secretion within the cavity, and a little later in the process, we have a desquamation of cells and the production of a certain amount of pus cells, so that the secretion becomes mucopurulent, but remaining thick and tenacious. With the advent of putrefactive organisms, especially when the antral involvement is the result of an apical abscess around the teeth, the secretion becomes liquified and has a foul odor. It is rarely, however, that in acute cases, not due to tooth infection, that there is any odor or liquifaction in the secretion within the sinuses. When the secretion is thin and purulent it is presumptive evidence that the patient has had the infection several days or it is an acute exacerbation of a chronic inflammatory process within the sinus. During the height of the inflammatory process the mucous membrane of the antra becomes enormously thickened, so that instead of being about 1/25th of an inch in thickness as it is normally, it may be so edematous and swollen as to nearly fill the entire cavity of the sinus. Such an enormous swelling of the mucous membrane blocks up the outlet of the sinus so that the cilia cannot easily remove this secretion, as the openings are no longer patent, and consequently the secretion is retained under pressure and most of it gets out only when the pressure is sufficient to overcome the obstruction at the orifice. It is such cases as these that have pain accompanying the infection. With the subsidence of the inflammation, the swelling of the mucous membrane recedes, leaving little or no thickening of the mucous membrane. However, it is our opinion that frequent attacks of infection of the sinuses result in a chronic thickening of the mucous membrane which may often be detected in our examination either by transillumination or by an x-ray of the sinuses.

Infection of the Para-Nasal Sinuses: Infection of the para-nasal sinuses is, I believe, very much more common than is usually thought. I believe that every cold in the head accompanied by such an amount of swelling of the nasal mucous membrane as to block up the nose and produce mouth breathing is accompanied by more or less involvement of the para-nasal sinuses but especially of the maxillary and ethmoid sinuses. For some reason the frontal sinuses and the sphenoids are less prone to infection.

Symptoms produced by infection of the para-nasal sinuses are two:

First: Discharge.

Second: A feeling of fullness in the head, or a distinct or throbbing pain referred to some portion of the head.

In the early stages the secretion like that from the nasal mucous membrane is mainly serous. In two or three days there is a thick, only slightly turbid mucoid secretion, to be followed in another two or three days by a secretion that is still thick and yellowish or slightly greenish in color, according to the color producing bacteria that are present. The pain in para-nasal sinus infections is, as was previously described, due to secretion retained within the sinus under pressure. No matter how much discharge there may be, if the normal openings of the various sinuses are sufficiently patent to allow the secretion to be eliminated as fast as it is formed, the patient will have no pain. One of the fallacious popular impressions is that acute sinusitis is accompanied by pain. Very frequently when I am examining a patient and diagnose an acute sinusitis the patient will remark, "Why, doctor, I have not had any pain." There seems to be an idea on the part of the medical profession that if they press over the cheek in the region of the antra, and it does not prove painful, they can rule out maxillary sinus involvement. This is a great fallacy as pain on pressure over the maxillary sinus would depend upon whether the secretion within the sinus were under pressure or not. The most common com-

plaint of a patient, who has pain in an acute sinus infection, is headache referred to the frontal region. This is true whether the maxillary, ethmoid or frontal cavities are involved. It is due to the fact that these three sinuses are innervated by the fifth cranial nerve. The maxillary sinus is innervated by the infra-orbital branch of the fifth and the pain is referred to the supra-orbital branch in the region of the forehead. It is easy to differentiate between the referred pain and the actual involvement of the frontal sinuses by pressing on the under portion of the frontal bone just internal to the supra-orbital notch. If the frontal sinus is involved, this region will be found to be exquisitely tender; also percussion over the anterior surface of the frontal bone will be painful. If these regions are not tender one should look for the cause of the pain as of either maxillary or ethmoid origin. One great peculiarity of sinus pain is the fact that it often begins about 9 or 10 a. m., becomes very severe an hour or two later and entirely disappears during the early afternoon. I have thought that the cause of this was the fact that during rest at night there was less blood supplied to the inflamed mucous membrane, consequently less secretion, but with the daily activities and increased heart action the swelling and the secretion increase with partial or complete blocking of the outlet resulting in pain. When the accumulated secretion is under sufficient pressure to be evacuated the relief of pressure and consequently the relief of pain occur. Periodic frontal neuralgia and headaches were formerly regarded as malarial in origin but now require thorough and careful examination of the para-nasal sinuses as a possible cause. The pain due to involvement of the sphenoidal sinuses is usually referred to the occipital region or to the ear.

To Diagnose Para-Nasal Sinusitis: The diagnosis of para-nasal sinus infection is rather difficult for the general practitioner to make unless he has had some training in rhinology. To the specialist, however, the diagnosis of these acute cases is usually not at all difficult, provided a systematic routine examination is carried out. The following routine is recommended:

First: Inspection of the nares will show a swollen, red, mucous membrane, almost if not completely blocking up the nasal passages. Some secretion may be found in the nose along the floor which has dropped down there from either the maxillary, ethmoid or frontal sinus, or from the nasal mucous membrane itself. The post-nasal examination will show a reddened, swollen posterior end of the inferior and middle turbinate and some secretion in the naso-pharynx.

Second: The nasal mucous membrane should be contracted with a weak 2% solution of cocaine, or 1/10,000 adrenalin, or an ephedrin solution. If the nasal mucous membrane is considerably swollen, a second application of these solutions may be necessary to sufficiently contract the nasal mucous membrane to enable one to make a proper and adequate inspection of the anterior part of the nose.

Third: While waiting for the solution to act, transilluminate the sinuses. The value of transillumination depends upon the examiner's experience in transillumination, and upon the anatomical arrangement, especially in the case of frontal sinuses. If one maxillary sinus illuminates less brilliantly than the opposite one, it is certain that there is something to account for the loss of illumination on the darker side. As the maxillary sinuses do not vary so much in size, it would be presumptive evidence that there is an involvement of the darker antrum. If both maxillary sinuses are infected, both will be darker than normal, and it is then that one's experience as a result of many transilluminations comes into play in interpreting the lack of illumination. One never gets as good an illumination in the thick-boned, heavy-jawed and fat individual as in the thinner boned, less adipose individual. Transillumination of the frontal sinuses is less reliable than that of the maxillary sinuses because of the frequent absence of or difference in the size of the two frontal sinuses.

Fourth: The fourth step is the removal, by swab or a suction apparatus, of the loose secretion along the floor of the nose.

Fifth: Inspection of the nose from within by the naso-pharyngoscope. This instrument should be passed along the floor of the nose through the nasal cavity until it touches the posterior pharyngeal wall, the prism being held in a vertical manner. One can thus view the posterior ends of the middle and inferior turbinates. On infection of the maxillary sinuses, one will almost invariably see a streak of thick, whitish or yellowish secretion in the angle between the upper and outer portion of the inferior turbinate, and the lateral wall of the nose. Such a secretion in this neighborhood indicates very clearly that it has come from either the maxillary, frontal or anterior

group of ethmoid cells. One may see a similar secretion between the middle turbinate and the septum, which secretion must come either from the posterior group of ethmoid cells or the sphenoidal sinus. Having inspected the posterior region of the nose the naso-pharyngoscope is brought forward and passed up into the middle meatus. Unless there is an enormous swelling of the mucous membrane of the lower border of the middle turbinate, one can often see secretion coming directly from the normal maxillary orifice.

Sixth: It is always possible that at the time of examination no secretion may be flowing from any of the sinuses, and therefore negative findings will be obtained by the preceding examinations but if the transillumination and the patient's other symptoms indicate an involvement of the sinuses, then a good x-ray of the sinuses should be ordered. These if properly taken and at the proper angles, will almost never fail to show the place and probable extent of the lesion.

I desire to urge rhinologists to learn to read their own plates, and not to rely entirely upon the opinion of the radiographer's interpretation of the plates. The radiographer has only the plates before him for his report, whereas the clinician has the plates, the patient's history and his subjective findings to aid him in forming his diagnosis.

Poor plates or plates taken at an improper angle are usually worthless as an aid to diagnosis.

Treatment: Very many cases of acute paranasal sinus infection are completely recovered from, along with the subsidence of the acute symptoms in the nose, without any treatment. A familiar example to many of you will be that during the later stages of a cold in the head and while we are blowing out a moderate amount of thick muco-pus,—suddenly on one day we will blow out from one or the other naris, an enormous quantity of secretion, with a general feeling of relief from fullness in the head. From that time on there is a rapid lessening in the amount of secretion we are blowing out. All patients with a sense of fullness in the head during an acute cold should be considered as having a sinus infection. The symptoms as well as the discharge is lessened by affording facilities for drainage from the sinuses. This can only be done when the outlets of these sinuses are not blocked up by swollen nasal mucous membrane. Therefore, three or four times a day if the nasal mucous membrane is kept contracted by the use of a spray of adrenalin or ephedrin, it will be found to facilitate drainage from the sinuses. In the stage where the secretion is thick and tenacious, I have found great relief by nasal irrigation with normal saline solution after contracting the nasal mucous membrane. It will usually be found that one nostril is more free than the other, and if one irrigates through the more obstructed side so that the irrigation may return through the freer side there is practically no danger of forcing any of the irrigation fluid mixed with the infected nasal secretion into the eustachian tube and induce an acute otitis media. I believe that such an irrigation helps to drag out the thick tenacious mucus that is protruding from the sinus so that oftentimes it will bring away every bit of secretion within the sinus. If contraction of the nasal mucous membrane and nasal irrigation do not give relief from the head pressure or pain, then it is necessary to relieve the sinus by washing it out. This can very readily be done in the case of the maxillary sinuses by cocainizing the naso-antral wall beneath the inferior turbinate with a 10% solution of cocaine. If 30 minutes is allowed for the anesthesia to fully act the naso-antral wall can be punctured, and the antrum washed out with practically no pain. It is usually more difficult to enter the frontal sinus owing to the swollen anterior end of the middle turbinate, and to the fact that the naso-frontal canal is smaller and often tortuous, making it difficult to get a canula into the sinus. If, however, the pain is sufficient, and there begins to be an edema over the upper eye-lid, more radical measures must be taken at once. After cocainizing the middle turbinate and the outer wall beneath it and the middle turbinate, excise the anterior third of the middle turbinate and with forceps cut away the anterior group of ethmoid cells which obstruct the naso-frontal duct. After this has been done the frontal sinus may be readily entered and irrigated.

The sphenoidal sinus can usually be entered with a probe and afterwards with a canula, its contents washed out.

How often a maxillary sinus, a frontal sinus or a sphenoid sinus may require to be irrigated depends upon the degree of infection. Daily irrigation for a period of from one to three or four weeks in the very severe cases may be necessary. I believe that these irrigations should be done daily rather than at less frequent intervals

as is the habit of some. In a certain number of cases of para-nasal sinus infections that have not become chronic, and whenever on irrigating a maxillary sinus the discharge that returns is of a thin milky character, I am convinced that we have to do either with a long-standing involvement of that sinus or an acute exacerbation of a chronic sinus.

Chronic Sinus Infections: Chronic para-nasal sinus infections are very much more common than is generally supposed. The symptoms are mainly those of discharge, or as the patient calls it, catarrh. Frequent use of the handkerchief or continual hawking back and expectorating a post-nasal secretion, is a common symptom. Pain is rarely an accompaniment of chronic sinusitis, and catarrh or discharge the sole symptom.

The routine examination for a case of suspected chronic sinusitis is the same as that for acute cases above described. Many cases of chronic sinusitis may be cured by simple washing out of the sinuses as was indicated in the acute cases, but if after continuing to irrigate daily for three or four weeks no apparent progress is made, it will be found necessary to adopt more active and radical surgery. Much can be done for these patients by intra-nasal surgery. In the case of the maxillary sinusitis, under local anesthesia, amputation of the anterior end of the inferior turbinate and removal of an area of the naso-antral wall beneath the inferior turbinate for two centimeters antero-posteriorly, and a centimeter or a centimeter and one-half vertically will usually permit of such drainage and ventilation from the maxillary sinus as to result in a cure. All of these patients however have a mucous membrane which is susceptible to recurring inflammation during acute head colds, and they will necessarily require some attention during these head colds. Most of the patients, however, may be taught to use a canula and irrigate their own maxillary sinus so as not to require attention from their physician. In chronic frontal sinusitis great relief and a fair proportion of cures may be obtained by amputating the anterior third of the middle turbinal and curetting away the anterior group of ethmoid cells so as to shorten and greatly enlarge the naso-frontal canal and make it easy for the physician to wash out the frontal sinus. I have a number of patients who are perfectly able to irrigate their frontal sinuses just as they do their maxillary sinuses during exacerbations of their trouble. There are, however, cases of arthritis, cardiac disease and other forms of systemic infection where nothing short of complete removal of the chronically infected mucous membrane lining the sinus would give any hope of relief. In such cases the Caldwell-Luc operation for the maxillary sinus and the Killian operation for the frontal sinus, ethmoid and sphenoid, are the best procedures likely to give the required benefit.

Sinusitis in Children: The frequency with which children have an infection of their sinuses is as great if not greater than is the case with adults. Up to the age of six years they may develop maxillary, ethmoid, and sphenoid infections. At an older age the frontal sinus infections begin. Owing to the small size of their nasal passages and the highly vascular turbinal bodies very moderate attacks of acute rhinitis serve to completely block the nasal passage thus readily blocking the ostia of their sinuses. The presence of adenoids and hypertrophied tonsils also adds to the insufficiency of nasal respiration. Operations for the removal of tonsils and adenoids will frequently result in lessening the attacks of cold in the head and sinus infections, but we sometimes find patients who continue to have colds, running noses and mouth-breathing, after such operations. It has been my observation that these children almost invariably have a chronic sinus infection. They also are prone to re-hypertrophy of the adenoid tissue owing to the fact that this tissue is not only continuously bathed in the bacteria laden secretion from the sinuses, but because the toxins of these bacteria are absorbed by the lymphatics of the nose and sinuses and carried back to the lymphoid tissue at the vault and lateral wall of the naso-pharynx. As an evidence of the latter we often see a thick ridge of lymphoid tissue on the postero lateral wall of the pharynx behind the posterior pillar of the fauces. The diagnosis of sinus disease in children is more difficult than in adults, and often can only be suspected until a good x-ray of the sinus is had. Children with colds in the head should be regarded as probable sinus victims and treated with ephedrin or adrenalin sprays to keep the nasal mucosa contracted so that the shallow sinuses may empty themselves. If they do not, then the maxillary sinus may be irrigated either under local or general anesthesia as is done with adults.

ANGINA PECTORIS*

Report of a Case Relieved by X-Radiation

Joseph H. Lucinian, M.D.,
Miami.

Angina pectoris is a disease limited almost entirely to business and professional men and occurs more frequently after the fourth decade. The exciting causes are muscular effort, mental emotion and distention of the stomach after a heavy meal. In a major attack, the patient is seized suddenly with an agonizing pain and a sense of constriction in the region of the heart. The pain usually radiates to the neck and down the arm. The patient turns pale and cold sweat breaks out over the surface of his face. The duration of the attack is brief and lasts but a moment or two but in that brief period, the patient goes through the sensation of dissolution and a horror of eminent death. Should he survive the attack he feels weak and exhausted for a day or two. The fatal outcome is not dependent on the severity of the pain; the patient may survive repeated major attacks but succumb to a minor one. Less commonly, the patient presents all of the characteristics of an anginal attack but the pain is referred to the hypochondrium instead of to the neck and arms.

Angina pectoris is not a pathological entity but a symptom complex in which no constant lesions are found at autopsy. In a large series of cases, over one-third show no anatomic changes in the heart, aorta or the coronaries. The most frequent finding is aortitis of syphilitic or rheumatic origin. Arteriosclerosis is observed in a smaller percentage; but many angina pectoris cases terminating fatally do not present distinct pathologic lesions. It is also true that equally as large a group may reveal aortitis or sclerosis who have not suffered anginal attacks in life. Clinically we find very little, if any, deviation from the normal in the force, rhythm or frequency of the pulse. Dyspnea and fever are absent. The blood pressure is not always elevated. In the uncomplicated cases, electro-cardiographic tracings are negative.

The medical treatment of angina pectoris is palliative but often ineffective. During the attack, nitro-glycerine and amyl nitrite will promptly relieve the spasm. Chloroform may be given without risk. Morphia is more effective in true angina pectoris than in angina due to coronary thrombosis. In addition, the patient should lead a quiet life, avoid anxiety and worry, eat a simple diet and regulate his bowel movements. The surgical treatment, originated by Jonnesco in 1916, is more risky but has proved successful in expert hands. Likewise, the injection of alcohol into the stellate ganglion offers relief for a variable period of time but is inconvenient and uncertain. Obviously, roentgen treatment is free from all these objections if it could bring about relief in an appreciable percentage of cases.

Relief of pain in angina pectoris by the roentgen rays is based on their analgesic property which was one of the earliest observations in their clinical application. As pointed out by Dr. Holmes, relief from pain following irradiation, is too prompt to be dependent mainly on the reduction of a tumor and in the case of metastatic carcinoma, the dose is often too small to cause any shrinkage of the tumor. Favorable results are reported in the relief of pain in thrombo-angiitis obliterans by roentgen irradiation over the lower spine in lower extremity affections and over the upper spine in upper extremity affections. Relief of hyperesthesia, trophic and circulatory disturbances, are recorded in poliomyelitis. In Raynaud's disease, decrease in the irritability of the autonomic nervous system is brought about by paravertebral roentgen irradiation. The list could be extended indefinitely. Suffice to mention the almost complete relief of pain in such conditions as acute mastoid and sinus affections, erysipelas, neuralgias, pruritis ani, arthritis, etc. Desjardins believes that nerve cells, which of all the cells of the body are the most resistant to irradiation so far as functional or organic damage is concerned, are acted on in a specific manner and their irritability diminished by irradiaton. There can be no doubt that roentgen rays possess a definite analgesic property. The pain in angina is referred to the cutaneous distribution of the first, second, third and fourth dorsal nerves or in angina of the hypochondrium, from the fifth to the ninth dorsal nerves. Ransom claims that pain travels along non-myelinated fibers.

In hyperthyroidism, cutting off of the sympathetic ganglion on one side, diminishes the secretion of the thyroid on the same side and roentgen radiation has the same effect. In angina pectoris, we are apparently dealing with an abnormal func-

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tioning of the sympathetic and parasympathetic systems in which an imbalance exists in their inhibitory and excitatory impulses.

Nemours and Barrieu, who regard angina pectoris as a crisis of the cardio aortic plexus, in 1929 irradiated the upper segments of all the sympathetic system in a series of fifty-four cases, all grave and chronic. In thirty-one there was complete relief of pain; in eight, partial relief; in five, no relief and one was aggravated. The remainder were unaccounted for. In this country favorable results by roentgen radiation were reported by Ecker in one case in 1924 and by Samuel and Bowie in nineteen cases in 1928. The latter do not specify the number who obtained complete relief. Sussman working under the supervision of Dr. Holmes in 1930, reports the result of sixteen cases treated at the Massachusetts General Hospital, none of which had responded to medical treatment. Ten showed definite improvement, of which six were completely relieved. The treatments were applied to the upper dorsal sympathetic ganglia on the theory that the process is probably a blocking of the pain impulse, similar in nature to injection of alcohol into the stellate ganglion. In one case, the pain was referred to the hypochondriac region and was relieved by irradiating the lower dorsal ganglia.

Case Report: The case I wish to report is that of a white, married, business man, 51 years of age, and whose past history presents nothing relevant to his present illness. Three years ago the patient developed an insatiable thirst and polyuria, which was diagnosed diabetes mellitus. Modified diet has controlled his symptoms to date. During the past year, the patient has been easily fatigued and dyspneic on walking. Eight months before consulting me he had a severe case of sciatica on the left side, necessitating rest in bed for four weeks. Seven months ago he had his first real attack of angina in the region of the heart. The pain was stabbing in character, radiating to the left arm and leaving him much fatigued and alarmed. He consulted a physician who warned him of future attacks and advised him against active, mental or physical exertions. Aside from the frequent minor attacks the patient has had four or five severe attacks, chiefly on retiring or following a hearty meal. He was unable to walk more than two or three blocks or climb stairs without experiencing pain in the region of the heart. Physical examination by his family physician revealed no abnormalities of the heart or in the electrocardiographic tracings. His blood pressure has varied from 160 systolic and 95 diastolic in July, 1933, to 145/85 in December, 1933. He gives no luetic history and the Wassermann test is negative. He indulges in alcoholic drinks occasionally and in coffee and tobacco not at all. When first consulted, I found the patient a well-developed and well-nourished man, about 51 years old, six feet in height and weighing 170 pounds. The heart sounds were normal, pulse rate 76 per minute, blood pressure 135/80. There was no evidence of cardiac hypertrophy or arteriosclerosis and no swelling of the ankles. The heart measurements by teleoroentgenogram were within the normal limits.

Treatment commenced on February 13, 1934, to the upper dorsal spine with the following factors: Area 12 cm. diameter, focal skin distance 50 cm., .5 mm. cu. and 1 mm. Al filter, 200 KV, 4 MA, 150 r units, measured in air, backscattering not included. A total of three treatments were applied to the same area ten days apart, delivering a total of 450 r or ½ skin erythema dose. During the two months he was under my care, the patient had several mild attacks of discomfort in his chest, chiefly on retiring or after a heavy meal but not at all of the severity previously experienced. Whereas walking a distance of several blocks would precipitate an attack, now he could walk for a distance of sixteen or more blocks and only feel a sensation of pressure in the chest. Since coming to Florida, it has not been necessary to resort to the use of amyl nitrite or nitro-glycerine. He has not gained in weight but has gained considerable strength. His sleep which was light due to a mental apprehension, is now very sound and restful.

In evaluating the results of x-ray therapy in angina pectoris, we must make due allowance to the role which a semi-tropical climate plays in non-degenerative cardiac diseases. However, I cannot but feel that in uncomplicated cases of angina pectoris, roentgen rays will bring about through their analgesic action, a diminution in the number and severity of the anginal attacks, enabling these patients to face life with more courage and less apprehension.

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Gaston H. Edwards, M.D., Alternate *Orlando*
(Terms expire after A.M.A. meeting, 1934)

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SURGICAL CONSCIENCE

In the July issue of this Journal we published on our editorial pages a bit of advise to the young surgeon by that Master Surgeon, Dr. Rudolph Matas. If, for any reason, you failed to read the two editorials appearing in that issue, do so at once. They will convince you that the real surgeon is an idealist, or else he would not choose as his life's work an art so filled with blood and human suffering. Dr. Matas also emphasizes that conscience, after all, is the true measure of a surgeon. A man may be ever so skillful in removing appendices, gall-bladders, and resecting stomachs, yet unless he possesses this surgical conscience, it is much better that he confine himself to some other work.

Listen for a moment. Listen to the closing paragraphs of a speech made by another great surgeon, Faure of Paris, France, in the presence of Their Majesties, the King and Queen of the Belgians. Perhaps as these forceful words thunder through our brains we may gain yet another conception of the meaning of "Surgical Conscience."

"Soon it will be half a century that I have lived in the hospitals. For forty years I have breathed each day in a sort of spiritual communion, with the sick and those operated upon, with those who suffer to live and those who suffer to die.

"When I see them ranged before me, in the evening of my memories, it is a people in a confused tumult which rises in my memory and whose vision fills me with pride and melancholy at the same time.

"Poor lost sick children, defenseless and without understanding! Old men whom inexorable death already grasps! Young women condemned by the unjust travail of maternity! What pains, what miseries, what unjust sufferings, how many innocent victims of a pitiless fate!

"And now we are in the days when we see the last years coming, when we feel the hour approaching to lay down, in our turn, the arms which we have used for so long to drive back death.

"Let us cast a glance backward into the mist of the past, so that our life work may unroll before our eyes. How many dead, how many dead! Their image now dim, now bright, alas, draws itself up before us. Many of them would perhaps still be living on this earth, if our judgment, instead of letting itself be guided by hope, had abandoned them to fate, and had refused to lead them to the table of blood, which for them was the altar of sacrifice, when for so many others it is the threshold of resurrection.

"May our souls remain serene and our hearts firm before the image of these dead. For our souls were pure and our hearts sincere when we placed on them the predestined hands which sought for health and found only death.

"Innocent victims of the Fate which hovers over the world, these dead, these poor dead, have not died in vain. Just as much as the soldiers fallen in battle, they are the obscure artisans of the victory, and their unrecognized sacrifice finds its recompense in the health and joy of those saved.

"How many dead! How many dead! How many living too. . . . It is a whole people that rises. It is a whole world of living people who are giving, and will continue to give, life to others.

"And there is that stronger, more intimate and deeper joy, for those who, in the meditations of their nights, or in the feverish inspiration of some moving moment have forged some new and decisive weapon against suffering and death. This will survive them and will prolong into the future their beneficent activity and will make the work of their brains a living thing, when their fame shall have disappeared and their name shall be stricken from the memory of men.

"Gather together, gather together then, ye phantoms who have disappeared, yet who are living at the present moment, ye children of the future who people our spirits with your shadows

and images; ye are the faithful companions of our memories and of our dreams, ye are our despair, our pride, and our hope!

"Forgive us, ye dead of the past, fallen on the field of honor. Ye are fallen in the hard battle which we fought to preserve life. Console us, countless multitude of the living, multitude of those whom we have saved, who very often appreciate us no longer. Console us, children of the future; although ye will not appreciate it, we gave life back to those who will give it to you. Gather together, dead and living. Let your silent images rise before us. And before the silent throng of all those who owe and will owe their lives to us, as well as those whom we have hastened into death, let the voice of our conscience mount into the silence and come to murmur to the echoes of our souls that the work of our lives has not been in vain, that we will have passed over the earth like the plowman who fertilizes the plain, scattering to the four winds of heaven the seed of future harvests."

MEDICAL CARE

Since the preliminary reports on various forms of activity by the Committee on Cost of Medical Care began to appear some three years ago, many individuals and also groups of individuals, medical, pseudo-medical and purely commercial, began to advance ideas about, and to offer various types of, insurance to help the policyholder meet drug, hospital and physicians' bills. Most of these plans were available to those earning a limited amount monthly while other plans would insure anyone, irrespective of the income, be it large or small. The chief trouble with the plans for those of limited income is the dislike on the part of the individual to reveal all his resources. Most of us at heart are tax dodgers! The wide open plans are almost without exception commercial; that is, a physician is hired at a ridiculously low salary and the promoters pocket a fat dividend.

The College of Surgeons now comes forward and proposes four groups for which more medical care should be available. (See page 70.) They are: 1, the indigent; 2, the uneducated and credulous; 3, those with limited resources; 4, those in remote communities. Somehow the College will study these groups and devise in cooperation with other agencies, some "periodic payment plan", free from the interest of commercial and intermediary organizations. With interest we await the report of their completed studies. However, the preliminary report was positive regarding one group, that is No. 1, the indigent; they should be a direct obligation of their own community and the physicians should receive remuneration. Several times in this column, we have advocated that very thing. The local County Medical Society could set a fee bill to cover this class of individuals. It might be nominal only, but there should be some remuneration for the time spent, the operations performed and the advice given. In all lines, save that of the practice of medicine, nothing is given away. No one ever heard of a life insurance agent giving away his premium, nor an automobile dealer a car, nor a merchant his goods. No more should we throw away our stock in trade.

Group 2 holds many of those who can well afford a physician and do employ one, usually patronizing those who make the greatest play to the galleries or the ones who charge the most. 'Tis a curious idea, we so often hold, that a free article has less real value than an expensive one; that is, advice given free by the most eminent physician will be heeded less than that of a high charging local man. To help the deserving in this class, the Board of Health, through its many workers, its program of preventative medicine, its syndicated articles, its radio broadcasts by eminent men and medical societies, is furnishing a vast amount of material for lay education. We feel a line is gradually being drawn between men of the profession and the many irregulars.

Group 3 need cause us little worry; all that is needed is for each family to adopt a family physician. He, knowing the needs and the resources, would be charitable in dealing with them. It is in this group that the greatest need is expressed. The conflicts of life are so demanding that few even could deduct enough from their salary to carry a policy for hospital attention without severely handicapping many, if not all of the members of the family. And unless all who could not meet their entire hospital charges came in, the insurance group plan would fail, for there must of necessity more be paid into the treasury than is withdrawn.

For group 4, the county might obtain the services of a physician paying him enough above his collections to make his income a livable one; or have a full time county physician, whose duty would be to ride into the sparsely settled regions, somewhat like the circuit rider of a past genera-

tion—an emissary of health, however, instead of one of salvation.

Whatever Utopian scheme is finally brought into being as a result of long and repeated agitation, we feel that the one of cooperative insurance for the so-called middle class—usually well sprinkled with ne'er do wells, who pose and never pay—dooms the plan to the scrap heap.

REPORT OF MEDICAL SERVICE BOARD OF THE AMERICAN COLLEGE OF SURGEONS, JUNE 10, 1934

The Medical Service Board of the American College of Surgeons respectfully submits the following report to the Board of Regents:

1. The American College of Surgeons affirms its interest and its desire to cooperate with other agencies looking toward the provision of more adequate medical service to the whole community.

2. The College believes that it is the duty of the medical profession to assume leadership in this movement and to take control of all measures directed to this end.

3. Encouragement should be given to the trial of new methods of practice designed to meet these needs, and a careful evaluation of their success should be the duty of the medical profession before they are offered for general adoption. All such new and experimental methods of practice must be conducted strictly in accordance with the accepted code of ethics of the medical profession in order that the interests of the patient and of the community may be protected.

4. The College recognizes for immediate study four groups of the population for whom more adequate medical service should be made available, as follows:

a. The indigent.
b. The uneducated and credulous members of the community.
c. Those who because of limited resources are unable, unaided, to meet the costs of serious illness and hospitalization.
d. Those living in remote districts where adequate medical service is not obtainable.

5. The care of the indigent sick should be a direct obligation upon the community and, (unless othewise compensated by intangible benefits such as staff and teaching appointments, opportunity and experience) physicians fulfilling this public service should receive remuneration.

6. The College should work in cooperation with other medical groups in order to dispel the ignorance and credulity of the public, and to bring the people to a proper realization of the protective and curative resources of modern medicine.

7. The American College of Surgeons recognizes that the periodic pre-payment plan providing for the costs of medical care of illness and injury of individuals and of families of moderate means offers a reasonable expectation of providing them with more effective methods of securing adequate medical service.

A number of different plans for the organization of such services have been proposed, although few have been in operation long enough to permit definite conclusions in regard to their success. It is to be desired that these experiments be continued. Conditions differ to such a degree in different parts of the country that a specific plan which is practicable in one place may require modification of details in other communities. The varying restrictions imposed by present insurance laws in different states further complicate the problem.

Periodic pre-payment plans providing for the costs of medical service may be divided into two classes:

A. Payment for medical service.
B. Payment for hospitalization.

It is suggested that plans for the payment of hospitalization alone (Class B) without provision for payment for medical service, may be considered the first project to be undertaken in the average community.

The American College of Surgeons believes that certain general principles can and should be established, the observance of which will tend to obviate known difficulties and dangers which may threaten the success of these special forms of medical service. These principles are as follows:

a. Periodic pre-payment plans for medical service should be free from the intervention of commercial intermediary organizations operating for profit. After deduction of the clerical costs of operation of the fund and such accumulation of reserve as may be advisable in the interest of the contributors or may be legally imposed, the full amount paid by the contributors should be available for medical and hospital services.
b. In the interest of the patient, the organization of plans for the periodic payment of medical and hospital costs must be under

the control of the medical profession. The medical profession must act in concert with the hospitals and such other allied services as may be involved in the individual project, together with a group of citizens representative of the whole community and of industry who are interested in the successful operation of the plan.

c. The principle of free choice of the physician and hospital by the patient must be assured to the end that the responsibility of the individual physician to the individual patient shall always be maintained. When hospitalization is required, this choice must of necessity be limited to the physicians and surgeons who hold appointments on the staffs of the hospitals participating in the plan or to those physicians and surgeons who are acceptable to the hospital. It is further recommended that only approved hospitals be admitted to participation in such a plan.

d. The compensation of the physician and of the hospital should be estimated with due regard to the resources available in the periodic payment fund and should be based upon the specific services rendered.

e. The organization and operation of any plan of this type must be free from any features not in accordance with the code of ethics of the medical profession which code has been established for the protection of the patient.

f. The medical organizations participating in such a plan must assume the responsibility for the quality of service rendered.

8. Periodic pre-payment plans for medical and hospital service should eliminate many of the conditions which have brought about the development of industrial contract practice. Until such plans have been more widely established certain general principles are here formulated with a view to the elimination of the commercial features of such forms of medical service.

a. The Minimum Standard for Industrial Medicine and Traumatic Surgery of the American College of Surgeons should be accepted. This Standard is as follows:

MINIMUM STANDARD FOR INDUSTRIAL MEDICINE AND TRAUMATIC SURGERY

1. That the industry shall have an organized medical department, or service, with competent medical staff including consultants and adequate emergency dispensary and hospital facilities and personnel to assure efficient care of the ill and injured.

2. That membership on the medical staff shall be restricted to physicians and surgeons who are: (a) graduates of scientific medicine holding the degree of Doctor of Medicine, in good standing and licensed to practice in their respective states or provinces; (b) competent in the field of industrial medicine and traumatic surgery; (c) worthy in character and in matters of professional ethics, that in the latter connection, the practice of the division of fees under any guise whatsoever be prohibited.

3. That there shall be a system of accurate and complete records filed in an accessible manner—a complete record being one which includes identification data; cause of illness or injury; nature and extent of illness or injury; detailed description of physical findings; special examinations such as consultations, clinical laboratory and x-ray; tentative or provisional diagnosis; treatment; prognosis with estimated period of disability; progress of illness or injury; final diagnosis; condition on discharge; end results; and such additional information as may be required by statute for Workmen's Compensation claims or for other purposes.

4. That all patients requiring hospitalization shall be sent to institutions approved by the American College of Surgeons.

5. That the medical department shall have general supervision over the sanitation of the plant and the health of all employees.

b. Physicians and surgeons, qualified as in paragraph 2 of the above Minimum Standard may properly be employed on a full-time or a part-time basis by industrial organizations to provide medical and surgical service for their employees, as follows:

i. To provide emergency service and first aid in injury or disease, and to provide adequate medical or surgical care for industrial injuries and diseases. Medical and surgical care of the families of employees, and of employees themselves, except for emergency and industrial injuries and diseases, should be provided by the industrial physician only in remote districts where other adequate medical service is not available.

ii. To provide pre-employment and periodic physical examinations.

iii. To study the hazards of the particular industry and to cooperate with other agencies in effecting such measures as may be needed for the prevention of injury and disease.

iv. To keep accurate records such as may be required by local Workmen's Compensation laws, and so complete as to serve for scientific investigation of industrial hazards with a view to their further prevention. These records are privileged communications, subject always to due process of law.

c. The sale of a contract by an industrial organization to an individual physician or group of physicians for medical and/or hospital service for its employees encourages commercial competition and is to be condemned.

d. Unethical practices in publicity, advertising, solicitation, and competition, either of a professional or of a financial nature, must be eliminated.

e. The accepted code of ethics of the medical profession, which is designed to protect the best interests of the patient, should apply to industrial medical service as to all other forms of medical practice.

MEDICAL SERVICE BOARD,
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REPORTS OF DELEGATES TO HOUSE OF DELEGATES, AMERICAN MEDICAL ASSOCIATION

Dr. Meredith Mallory, Orlando:

As a delegate from the Florida Medical Association to the recent meeting of the American Medical Association I would like to report my impressions at least. The work transacted by the House of Delegates will be given better and in more detail than I can possibly give; however, there are some things that I would like to call to your attention.

1. The Florida Medical Association should send active delegates that make it their business to be present and they should not be changed from year to year if their work is satisfactory, but should remain as delegates from other states do, year after year, so that the Association may derive the benefit of their contacts. I make that statement from the fact that when my credentials were handed in there was quite some surprise evidenced that Florida was represented by two delegates. Also Florida received no recognition in the way of committee appointments due, I feel, to lack of activity of our delegates in recent years. Some method of defraying at least part of the expenses to the meeting should be devised. Other State organizations do that and some send also their secretaries in order that proper contact can be kept with the affairs of the American Medical Association.

2. In regard to having the A. M. A. convention in Florida I feel it could be had, provided that facilities could be furnished. It would have to be held in Miami but unless there is some building there that could house the scientific and commercial exhibits it would be useless to ever send out an invitation. I understand that Miami has no such place at the present time and unless there are prospects of one being built we had better forget all about such a meeting. However, if there is any chance that this could be arranged it would be a big boost to the Florida Medical Association besides being a great benefit to the State as a whole.

Dr. F. Clifton Moor, Tallahassee:

Your delegate submits the following report of the Cleveland meeting of the A. M. A. House of Delegates:

The details of the proceedings can be readily obtained from the official minutes already published in the Journal, but it is perhaps worth while to call attention to the exceptional number of resolutions submitted, most of which were in connection with some phase of the medical economic situation. It is also of interest to report that the overwhelming sentiment of the House of Delegates was opposed to any form of socialized or state medicine, unless the service was under the complete control of the profession. The principle back of all decisions was that it would be against the best interests of the public and the profession alike, for any organization,

private or governmental, to act as middleman between doctor and patient, and especially if this intervening organization interfered in any way with the free choice of patients in seeking medical advice, or profited directly or indirectly from fees paid for professional services.

Another decision of general interest was the action to table all resolutions endorsing the popularization of birth control measures. The sentiment back of this action was determined more by expediency than scientific facts. In view of the varying personal and religious views on the subject it was thought best to avoid official sanction by the A. M. A., leaving the matter to the discretion of the individual physician, since in its practical application, the individual opinion would, in any case, be the determining factor.

Both of your delegates are convinced that our State Association should adopt the policy of sending the same delegates to the A. M. A. for several consecutive years. We were impressed by the fact that, unless advantage is taken of repeated personal contacts, our State will not get its fair share of committee assignments or other worth while recognition.

RADIO BROADCAST, 1932-33

The following broadcast was arranged by the Public Relations Committee of the Florida Medical Association and given over station WRUF, Gainesville:

THE IMMUNE DEFENSES OF THE BODY*

L. Y. Dyrenforth, M.D.
Jacksonville

The word *immunity* refers to the presence in the human body of agents which operate against the invasion of diseases. It means also that these agents are of more than one kind, each suited to resisting a particular disease. Just as in modern warfare we have a special kind of artillery for combating attacks from the air, and as we have in ancient times built walls and moats around our homes, so in fact has the body developed an intricate mechanism within itself to resist the process we call *disease*. This defensive power, this mechanism of resistance in warding off disease, or delaying its invasion, or weakening its effects, we know as *immunity*.

In times past this conception amounted to mere speculation, principally being concerned with the effects of so-called "curses" or "spells," or with the influence of the planets, the workings of bad air, and what-not.

Today our ideas of the nature and causes of disease are due to the knowledge gained from finding and appreciating the changes which occur in diseased bodies and tissues, and also, demonstrating by laboratory methods the actual existence of living agents (or bacteria) which produce diseases. These aids to modern medical knowledge are named *Morbid Anatomy* and *Histopathology*, and *Bacteriology*. In our own generation, in addition, the experimental method has added greatly to a well-ordered understanding of the facts concerned with the workings of disease. An example of the trend of scientific medicine is to be seen in that what were known to our grandparents as "fevers" are now classified as specific infectious diseases, because a definitely known causative agent can be ascribed in each instance.

For a concise and descriptive grouping of diseases, the classification which is based upon *causation*, and originating with the medical department of the United States Army, is helpful. The causative agents in order of frequency are classed as *Animate, Inanimate, Unknown*. In the *Animate* group these agents are bacteria, viruses, worms, malarial parasites, and so on, which produce *infections*. The type of defense in this case is immunity, or natural resistance.

In the *Inanimate* group these causative agents are physical forces (causing injuries), and chemical forces (causing intoxications, addictions, and conditions arising from lack of vitamines). The type of defense here is tolerance and habituation.

In the *Unknown* group we have the not-well-understood causative agents, which produce diseases of metabolism and of constitution. The type of defense in this group is not understood. Why some individuals are peculiarly susceptible to disorders of the endocrine system, for instance, and others are not, remains for a future generation to reveal.

As to these three very general classes of diseases and their causative factors, only the first, or animate group, can be discussed in such a treatment as this. This group is concerned with about half the diseases of mankind. It would be pertinent to include here, if time permitted, the several disease processes resulting from foreign proteins such as asthma, hayfever, and urticaria.

*Broadcast delivered under auspices of Florida Medical Association over Station WRUF, Gainesville, April 30, 1933.

To begin with, these *animate sources* of disease are many and varied. Those which are well known are ordinary bacteria, such as are responsible for common infections like typhoid fever and tuberculosis, the worms which infest the intestinal tract, the spirochetes of syphilis, the fungus growths of athlete's foot, and the parasites of malaria. Those which are not so well known are the organisms which as yet are invisible to our methods of search, and which are called *filtrable viruses* by reason of the fact that they, or their disease-producing products, can pass through the finest of filtering media. These latter include hydrophobia (or rabies), and poliomyelitis (or infantile paralysis).

An important consideration in resistance is the physical barrier of normal healthy skin. This is a digression, however, from the conception of immunity discussed here, and is only mentioned in passing.

The types of resistance usually considered are: (1) Natural Immunity and (2) Acquired Immunity. Natural Immunity is an inborn affair and ordinarily is of theoretical interest only. Examples of this type are the inherent, or natural, resistance of most animals to leprosy, of most animals to pneumonia; and further, we do not see such diseases as typhoid fever, measles, or scarlet fever occurring spontaneously in lower animals; nor do the warm-blooded animals fall heir to the infections peculiar to those of the cold-blooded group. A side-issue of natural immunity is to be seen in *racial immunity*, of which there are several familiar instances. The white race is less susceptible to tuberculosis than the black race, the former having developed this natural immunity through centuries of intimate contact, a condition which has been denied races of recent savage origin, and as a result these are fertile, defenseless breeding grounds for the bacillus of tuberculosis. For similar reasons the aboriginal races are not so apt to acquire malaria or hay-fever, being on more familiar terms, as it were, with the factors causing these scourges of civilization.

Our public health measures are more concerned with this second type of resistance mechanism, acquired immunity, which is of two kinds, active and passive. This acquired immunity may be either artificially or naturally imposed upon us. For a period of months after birth the normal breast-fed infant is practically immune to diphtheria and many other diseases because these factors of resistance have been bestowed through its mother's blood stream. Another form of naturally acquired immunity is having a disease such as scarlet fever, and recovering from it. This establishes immune forces which thereafter exist in some degree or other.

Although this is very important, it is much more important to understand the mechanism of the artificially imposed kind of acquired immunity, for which we are indebted to our established health organizations.

As has been stated, the two kinds of artificially acquired immunity are the active and the passive. To define these briefly, active acquired immunity is that which is conferred by injecting into the system either bacteria or preparations made from bacteria. These may be the living germs themselves, or the germs after killing them by heating, or extracts made from the germs. In each case, however, the germ or germ products used are those which are concerned with the particular disease in question.

Bacteria, like other living matter, contain proteins. Each kind of germ exhibits its own particular protein, so that when injected into another living organism, such as the human, there is immediately built up an antagonistic substance within this injected individual. This substance, the actual nature of which is purely hypothetical, is called an antibody; the injected protein substance which excites such formation is called an antigen. When thus formed, antibodies perform their duties in several ways. For instance, if they are called upon (as in diphtheria) to neutralize toxins, they act as antitoxins; if they destroy living germs, they are known as bacteriolysins. These powerful antagonistic bodies may remain potent for months—even years—and so confer a more or less enduring immunity. Thus, when a person is immunized by injections of dead typhoid bacteria, as during the World War, he may be exposed without danger to conditions which ordinarily would have meant sure infection with the disease. This, then, is active immunity. Smallpox vaccination is another example of acquired immunity, in which the vaccinated person is protected by being given a modified form of the disease.

Passive immunity is that which is conferred by taking the serum, or liquid part of the blood, from a person or animal who has had active immunization, and injecting it into another individual who is to be immunized. The reason this is called pas-

sive immunity is that this last individual is not concerned in the production of such immunity in the same way as the actively immunized individual, whose body cells actually produced the antibodies which made his serum capable of performing such immunity. It is this kind of "transferred" immunity with which we are most familiar in daily life.

In this way those immune sera, diptheria antitoxin and toxin-antitoxin, are made from horses' blood. Selected animals are treated with the toxin of the disease, and after a period in which antagonistic forces or antibodies, are developed, some of the horse blood is taken from a vein, and upon separating from it the red blood corpuscles and purifying it this serum then becomes "diphtheria antitoxin." The horses do not suffer ill effects from the treatment and are willing volunteers over a period of years to this important phase of public health endeavor. What is known as "toxin-antitoxin" is diphtheria toxin neutralized with anti-toxin, a procedure which curbs the effects of the "straight" toxin without detracting from its immunizing abilities. In recent times, another immunizing material called toxoid has been introduced and may largely replace toxin-antitoxin in immunization against diphtheria. The purpose of toxin-antitoxin is prevention; the purpose of antitoxin is to aid the body in curing the disease, once it has become established.

A word about early conceptions of immunity. Robert Koch, the pioneer bacteriologist of fifty years ago, thought it due to some variation in the condition of the blood, without knowing what this condition was. Fodor considered that certain antiseptic substances were acquired by the blood under circumstances of immunization. Pasteur's "exhaustion theory" held that resistance to disease following recovery was due to the fact that the first invasion used up nutritive substances which left succeeding invaders without anything to live on — a condition somewhat similar to growing several successive crops on unfertilized soil. Metchnikoff finally grasped the situation and pointed the way toward clarifying it. Briefly, he showed that the leucokytes, or white blood cells, are endowed with powers for destroying invading microorganisms by engulfing and absorbing them. Bordet and Ehrlich were later instrumental in establishing that specific substances are built up, not only in the white blood cells, but in the red cells and in other cells elsewhere, when a disease process invades the system. Finally, then, the substance elaborated by cells so influenced is the instrument which in the body fluids acts directly upon the disease-producing elements.

In conclusion it is to be seen that the study of immunity is but one cog in the intricate mechanism of modern medical science. It is so closely linked with environment and heredity that it is not capable of being worked out in the laboratory alone. The family doctor, the public health official, and the laboratory worker are together concerned with the problem, and their fields converge in approaching its solution. Dr. Walter B. Jones sums up the matter significantly by stating: "We cannot think of life as an isolated fact, but only as a complex, the result of a large number or coordinated facts which should be in harmony with one another, but which unfortunately often are in disharmony. Health and disease too are not isolated facts, and it is to be desired that physicians, whose aim it is to promote health and to combat disease, should realize that man and his diseases should be viewed as parts of a complex in which the environment, both physical and mental, plays an important role, and that one should not be neglected by him, in practice, in teaching, and in research."

STATE NEWS ITEMS

The many friends of Dr. Crowell W. Johnston of Jacksonville will be glad to learn that he has recovered from a recent appendicitis operation.

* * *

Dr. F. W. Chappell of Hastings announces his removal to Madison. Dr. Chappell will operate the Yates Sanatorium in that city.

* * *

Dr. and Mrs. S. B. Forbes of Tampa recently spent two weeks in Denver where Dr. Forbes took a post-graduate course in ophthalmology and otolaryngology.

* * *

Drs. E. Clay Shaw and B. L. Whitten of Miami are at present on a travel tour in South America.

* * *

Dr. L. A. Hodsdon of Miami has returned from Nassau and the Windward Islands. He explored caves at Gambier Lake, Port Howe, Macqueens and the Bight. Cave bats, soldier crabs, tree toads, poisonous spiders and a few mollusks were taken for the University of Miami.

Dr. S. E. Driskell of Jacksonville was elected president of the State Board of Medical Examiners at their semi-annual meeting held in Jacksonville, June 13 and 14, 1934.

* * *

Dr. Courtland D. Whitaker, formerly of Raiford, announces the opening of offices in the Dekle Building, Marianna.

* * *

Dr. J. A. Redfearn and family of Albany, Georgia, spent a few days recently in Jacksonville as the guests of Dr. and Mrs. T. H. D. Griffitts. Dr. Redfearn was very active in the malaria control program during the time he was chairman of the Health Committee of the Kiwanis Club and was voted the Governor Hardman Award by the Georgia Medical Society for outstanding contribution to the public health program of that state.

* * *

Dr. W. H. Spiers of Orlando, who has been in Pittsburg as an expert witness in psychiatry in a court case, has journeyed to Chicago where he will attend a post-graduate psychiatric clinic. Incidentally, he will visit the Fair.

* * *

Dr. and Mrs. Fuad H. Hanna of Miami announce the birth of a son, Stanley George, on June 15th.

* * *

Among those in attendance at the meeting of the Chattahoochee Valley Medical and Surgical Association, held at Radium Springs, July 10 and 11, were the following Florida doctors: M. Jay Flipse and M. C. Wilson, Miami; Frank D. Gray and C. D. Christ, Orlando; T. Z. Cason, Julian Gammon, Gerry Holden, Edward Jelks, W. M. Shaw, J. Knox Simpson and H. Marshall Taylor of Jacksonville.

* * *

Dr. John S. Helms, Jr., of Tampa is spending several weeks in Rochester, Minn., where he is attending clinics in surgery at the Mayo Clinic.

* * *

The many friends of Dr. E. W. Warren of Palatka will be pleased to learn that his youngest son, Walter, was nominated a candidate for the House of Representatives in the next Legislature. Mr. Warren, who is 21 years of age, recently finished a law course.

Dr. Jack Halton of Tampa has returned from a three weeks' visit in Cincinnati. While in that city Dr. Halton did work in proctology at the Cincinnati University Hospital, Christ's Hospital, the Good Samaritan Hospital and the Jewish Hospital.

* * *

Dr. N. P. Myers, formerly of Parrish, has moved to Holopaw, where he has opened offices.

* * *

Dr. Shaler Richardson of Jacksonville, secretary of the Association, has returned from a two weeks' trip to Canada and New York where he attended medical meetings.

* * *

Dr. H. L. Brillhart of Jacksonville has returned from Baltimore, Md., where he attended clinics.

* * *

The following members of the Florida Medical Association registered at the convention of the American Medical Association held in Cleveland, Ohio, June 11-15:

L. E. Bransford, Jacksonville.
B. A. Chapman, Jacksonville.
L. W. Cunningham, Jacksonville.
W. M. Davis, St. Petersburg.
J. C. Dickinson, Tampa.
O. O. Feaster, St. Petersburg.
Jack Halton, Tampa.
E. M. Hendricks, Ft. Lauderdale.
John A. Herring, St. Petersburg.
W. T. Hotchkiss, Miami.
W. J. Johnston, Sarasota.
Walter C. Jones, Miami.
David R. Kennedy, Sarasota.
Roscoe H. Knowlton, St. Petersburg.
E. J. Lawrence, Winter Garden.
H. B. McEuen, Jacksonville.
Meredith Mallory, Orlando.
Eugene B. Maxwell, Miami Beach.
Frank C. Metzger, Tampa.
Edith P. Mols, Tallahassee.
F. Clifton Moor, Tallahassee.
T. Earl Moore, Miami.
Frank R. Morrow, Miami.
Rosalie S. Morton, Winter Park.
E. Sterling Nichol, Miami.
S. R. Norris, Jacksonville.
Richard C. Norton, Miami Springs.
Cayetano Panettiere, Miami Beach.
H. J. Peavy, Ft. Lauderdale.
Warren Quillian, Coral Gables.

Gerard Raap, Miami.
Marvin Smith, Miami.
Robert T. Spicer, Miami.
Alvord L. Stone, Tampa.
H. Marshall Taylor, Jacksonville.
Iva C. Youmans, Miami.

* * *

The Gynecean Hospital Institute of Gynecologic Research of the University of Pennsylvania, is conducting an intensive study of families into which congenitally malformed individuals have been born.

Special interest centers in families in which malformations have appeared in two or more children. Physicians who have knowledge of any such families are urged to communicate with:

Dr. Douglas P. Murphy,
Gynecean Hospital Institute,
University of Pennsylvania,
Philadelphia, Pa.

* * *

Dr. W. M. Rowlett, Secretary of the State Board of Medical Examiners, reports that of the seventy-three applicants who took the examination in Jacksonville, June 11th and 12th, there were sixty-six that passed the examination and were issued licenses. There were seven failures. The applications of twenty-nine physicians were turned down by the Board. Of these, twenty-four were foreigners and five were graduates of low grade American colleges, whose diplomas are not accepted by the Board. Five of the applicants are natives of Florida. Dr. George F. Wilkins, of the Riverside Hospital, Jacksonville, a graduate of Harvard Medical School, 1932, led the class with an average of 92.5%. Dr. Virgil M. Bradshaw, of the Tampa Municipal Hospital, who took his pre-medical work at the University of Florida, and graduated from Rush Medical College in 1933, was second high with an average of 91.9%.

Licenses have been issued to the following successful applicants:

Baldwin, Donald M., Jacksonville.
Ball, Elmer J., Manitowoc, Wisconsin.
Bartleson, Fred D., Ft. Myers.
Batten, Glenn D., Yuma, Tenn.
Bieker, Arthur J., Tampa.
Bond, Benjamin J., Savannah, Ga.
Bosworth, Joe M., Jr., Atlanta, Ga.
Bowen, Louis R., Tifton, Ga.
Bradshaw, Virgil M., San Antonio.
Bramlitt, Charles H., St. Petersburg.
Bratley, Forrest G., Miami.
Broadbent, Mary, Elwood, Ind.
Calvert, Read N., Orlando.
Charlton, H. R., Bronxville, N. Y.
Click, Gustavo N., Pensacola.
Dowlen, Otto S., Lynnville, Tenn.
Drennen, W. Earle, Birmingham, Ala.
Elliott, Charles A., Chicago, Ill.
Erwin, A. L., Nashville, Tenn.
Feld, Nathan, Richmond Hill, N. Y.
Gardner, Herbert D., Coconut Grove.
Girvin, Howard W., Chattahoochee.
Griffin, Taylor W., Quincy.
Guinand, P. H., Tampa.
Hall, Young L., Jr., Adel, Ga.
Hallum, Alton V., Atlanta, Ga.
Hasty, Frederick E., Nashville, Tenn.
Hewlett, Frank W., Coral Gables.
Hofling, Charles A., Jr., Cincinnati, Ohio.
Hogan, Cecil M., Hialeah.
Ingram, Hollis C., Orlando.
Jenkins, O. W., Chattahoochee.
Kay, Milton B., Miami.
King, Raymond H., Jacksonville.
Leu, Raymond H., New Martinsville, W. Va.
Macdonald, John T., Norristown, Pa.
McCauley, Everett W., Tampa.
McKenzie, Jack A., Miami.
Mikell, Robert F., DeLand.
Mitchell, William S., Atlanta, Ga.
Moon, P. L., Jr., Atlanta, Ga.
Murphree, Walter E., Tallahassee.
Murray, O. B., Rossville, Ga.
Park, Manasseh B., Ridgewood, N. J.
Peacock, William F., Vidalia, Ga.
Putnam, James H., Alabama City, Ala.
Rice, William P., Pensacola.
Ricker, Samuel F., Orlando.
Roth, Edward, Brooklyn, N. Y.
Scott, Douglas G., Altamonte Springs.
Shepard, Richard C., Opelika, Ala.
Stem, Leon T., Chattanooga, Tenn.
Stephenson, Gordon A., Buffalo, N. Y.
Stoner, Cyrus H., Attapulgus, Ga.
Thompson, Cornelius M., Jacksonville.
Thomson, W. R., Miami.
Timberlake, Gideon B., Stevenson, Ala.
Travers, Milton P., Miami.
Vallotton, Joseph R., Valdosta, Ga.
Wakefield, Harry A., Charlotte, N. C.
Walker, Henry M., Nashville, Tenn.
Watson, Samuel E., Lakeland.

Wells, William C., Cave City, Ky.
Wilkins, George F., Jacksonville.
Wochinski, Aloysius J., Chicago, Ill.
Wynn, Robert S., Jacksonville.

* * *

Dr. L. W. Holloway of Jacksonville has returned from Saluda, N. C., where on July 24 and 25 he delivered lectures at the Southern Pediatric Seminar on "Premature Infants" and "Vomiting in Infants and Children."

COMPONENT COUNTY SOCIETIES

DADE COUNTY MEDICAL SOCIETY

At the meeting of the Dade County Medical Society, held August 3, at the Huntington Club Rooms, Miami, the following program was presented:

"Skin Tumors"—Charles D. Cleghorn, Miami.
"Gritti-Stokes Amputation for Gangrene of the Leg"—J. W. Snyder, Miami.

LEON-GADSDEN-LIBERTY-WAKULLA-JEFFERSON COUNTY MEDICAL SOCIETY.

The quarterly meeting of the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society was held at the Elks Club, Tallahassee, July 19th, at 3:00 p. m. The following scientific program was presented:

"Report on Three Cases of Malaria with Hemoglobinuria"—B. F. Barnes, Chattahoochee.
Discussion: M. F. Boyd and Marion Salley, Tallahassee.
"Causalgia"—R. F. Godard, Quincy.
Discussion: W. W. Massey, Quincy, and J. K. Johnston, Tallahassee.
"The Prevention of Puerperal Infection"—L. L. Dozier, Tallahassee.
"A Follow-up Report on a Case of Cirrhosis of the Liver"—John L. Williams, Tallahassee.

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The Woman's Auxiliary to the American Medical Association sends the following Convention notes on the 12th annual meeting held at Cleveland, Ohio, June 11-16, 1934.

List of New Officers:

President—Mrs. Robert Tomlinson, Wilmington, Del.

President-elect—Mrs. Rogers N. Herbert, Nashville, Tenn.

First Vice-President—Mrs. Rollo K. Packard, Chicago, Ill.

Second Vice-President—Mrs. Otis Lamson, Seattle, Wash.

Third Vice-President—Mrs. J. Bonar White, Atlanta, Ga.

Fourth Vice-President—Mrs. William Lett Harris, Norfolk, Va.

Secretary—Mrs. Elmer S. Whitney, Detroit, Mich.

Treasurer—Mrs. Eben J. Carey, Milwaukee, Wis.

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Mrs. F. W. Scatena, Sacramento, Calif.
Mrs. M. L. Stevens, Asheville, N. Carolina.

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Mrs. Arthur B. McGlothlan,
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Legislation:
Mrs. Walter Jackson Freeman, Jr.,
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Judging from the interesting State reports turned in at the A. M. A. Convention, we feel that Auxiliary work is meeting a very definite need in the field of organized medicine. May we continue to go forward and cooperate to that end, that the sacrificial services rendered by the Medical Profession may become more highly esteemed by the public at large.

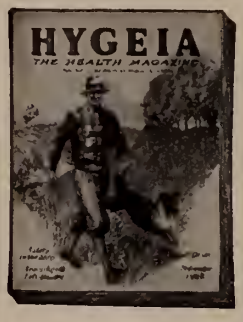
* * *

The following report comes to us from Mrs. J. Ralston Wells of Daytona Beach and Mrs. A. K. Wilson of Jacksonville, who attended the Short Course for Women, known as the College of Leadership, held in Gainesville June 25-30, which contained much to interest Auxiliary members. Under the Extension Division of the University of Florida the library of the lovely new P. K. Yonge Laboratory School gave ample space for the lectures, while for living accommodations the dormatories and cafeteria were placed at the disposal of those attending.

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Fifty speakers prominent in their various fields contributed lectures followed by optional discussion for those who wished to pursue the subject further. The program was planned under ten headings. After brief devotionals, talks were given on some phase of Club Organization and Management, Community Social Problems, Public Welfare, Law, Agriculture and Gardens, Recreation and Use of Leisure Time, Public Health, State and National Problems and Problems of Citizenship. Entertainment was arranged for the evenings. The section on Recreation and Use of Leisure Time was headed by Miss Fannie B. Shaw, Associate Professor in the University of Florida Health Department. Other University professors very generously contributed to the program in splendid lectures on a variety of subjects—Sociology, Law, Economics, Drama, History and Political Science, Chemistry, Gardening and Philosophy.

Miss May McCormick, executive secretary of the Florida Tuberculosis and Health Association, arranged lectures on medical subjects along the line of preventive medicine. Dr. A. W. Sears of Jacksonville spoke on Dental Health Education; Dr. T. Z. Cason, of Jacksonville, Diseases of Middle Age; Dr. W. A. Claxton, Jacksonville, Tuberculosis a Community Problem: Dr. W. S. Welch, Gainesville, Social Hygiene; Dr. Gerry R. Holden, Jacksonville, Cancer.

Cooperating with Miss McCormick, Mrs. J. Ralston Wells of Daytona Beach, State Auxiliary Public Relations Chairman, and Mrs. A. K. Wilson of Jacksonville, Program Chairman of Duval County Medical Auxiliary, distributed leaflets "A New Deal in Health" immediately following Dr. Cason's talk on Diseases of Middle Age. They also distributed pamphlets on cancer following Dr. Holden's talk on cancer.

One hundred twenty-five club women attended the course, representing sixteen cooperating organizations. The Parent-Teachers Association was most fully represented, the Woman's Club next, the Garden Club third. The course will be repeated next year and we hope that a larger number of Auxiliary members will take advantage of this splendid opportunity for broader education.

* * *

Of much interest to our State Auxiliary is the fact that Volusia County Medical Auxiliary distributed 2,000 copies of our pamphlets, "A New Deal in Health", in Daytona Beach, having sent them out with the water bills, with the approval of the City Board of Health.



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The serum of 32 persons, tested before receiving Refined Tetanus Toxoid, showed but traces of tetanus antitoxin, about 0.0001 unit per cc. They were bled 90 days after receiving a dose of Refined Tetanus Toxoid (alum precipitated). Tests for antitoxin content of their serums showed from 1/1000 to 1/400 unit of antitoxin per cc. In order to develop a higher active immunity a second dose of Refined Tetanus Toxoid (alum precipitated) was administered. In each of these 32 individuals, bled thirty days after the second dose, the antitoxin content had been increased to from 1/10th 9.0 units of antitoxin per cc. of serum, *i. e.,* the antitoxin content of the serums of individuals receiving two doses of Refined Tetanus Toxoid was increased 1000 to 90,000 times the amount found in their serum before Refined Tetanus Toxoid was given.

While the amount of tetanus antitoxin contained in the blood of persons receiving two doses of Toxoid is distinctly higher than following a prophylactic dose of 1500 units of Tetanus Antitoxin, it is considered advisable to give a third dose of Toxoid, to those actively immunized, when they meet with an injury through which tetanus bacilli may enter the tissues. The third injection of Toxoid raises the amount of antitoxin in their blood to a much higher level, *i. e.,* produces a still higher immunity.

Refined Tetanus Toxoid is a prophylactic agent; it should not be used for treatment of tetanus infection. Tetanus patients must be given large doses of Tetanus Antitoxin.

PRACTICAL VALUE OF REFINED TETANUS TOXOID

Persons engaged in pursuits in which injuries occur frequently, as miners, cement workers, artisans in different kinds of construction work, mechanics, agriculturists, stablemen, truck drivers, and all persons exposed to injury, may be actively immunized with Refined Tetanus Toxoid. The importance of the use of Refined Tetanus Toxoid (alum precipitated) in the prophylactic treatment of all the personnel of the military service is evident.

Refined Tetanus Toxoid (alum precipitated) is of value in the prophylaxis of tetanus because:

1. Two doses of 1 cc. given at an interval of one to two months induce an active immunity in three to six months.
2. Local or general reactions are negligible.
3. It obviates sensitization to serum which may follow the injection of prophylactic doses of Tetanus Antitoxin.
4. The cost of immunization is relatively low.
5. The active immunity induced with Refined Tetanus Toxoid (alum precipitated) probably lasts for several years while passive immunity, induced by a prophylactic dose of Tetanus Antitoxin, lasts only for a few weeks.

Literature on Refined Tetanus Toxoid may be secured by addressing The National Drug Company, Philadelphia.

Refined Tetanus Toxoid is furnished as follows:

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REFERENCES:

[1]Bergey, D. H., and Etris, S.: Immunization of Humans with Alum Precipitated Tetanus Toxoid. Am. Jour. Pub. Health, 24: June, 1934.

Bergey and Etris: Tetanus Toxoid in Prophylaxis Against Tetanus. Proc. Soc. Exp. Biology and Med., 30. 1037, 1933; Jour. Infec. Diseases, 53: Nov. Dec., 1933, 331.

[2]Wells, Dewey M., Graham, Arthur H., Havens, Leon C.: Diphtheria Toxoid Precipitated with Alum. Am. Jour. Pub. Health, 22: 648, June, 1932.

MERTHIOLATE

Pasteur once said: "If it is terrifying to think that life may be at the mercy of the multiplication of those infinitesimally small creatures, it is also consoling to hope that science will not always remain powerless before such enemies." Pasteur was a savant peering into the next century just as scientific observers are today glimpsing the future accomplishments of the laboratory worker.

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SCHEDULE OF MEETINGS—COMPONENT SOCIETIES FLORIDA MEDICAL ASSOCIATION

COUNTY SOCIETY	SECRETARY	MEETINGS				Dues Paid.
		Date	Time	Place	Luncheon?	
Alachua	Harry M. Merchant, M.D., Gainesville.	2nd Tuesday	12:00 Noon	White House Gainesville	Yes.	86%
Bay	Allen H. Miller, M.D., Millville.					71%
Brevard	L. K. Hicks, M.D., Melbourne.	2nd Tuesday		Varies	Yes.	56%
Broward	O. C. Brown, M.D., Ft. Lauderdale.	Last Wednesday.	8:00 P.M.	Elks' Hall Ft. Lauderdale	No.	94%
Columbia	T. H. Bates, M.D., Lake City.	1st Monday	7:30 P.M.	Blanche Hotel Lake City		100%
Dade	Robert T. Spicer, M.D., Miami.	1st Friday	8:30 P.M.	Club Room Huntington Bldg. Miami	Occasionally.	92%
DeSoto-Hardee-Highlands	L. W. Martin, M.D., Sebring.	2nd Tuesday	8:00 P.M.	Varies	Yes.	93%
Duval	B. F. Woolsey, M.D., Jacksonville.	1st Tuesday	8:15 P.M.	Mayflower Hotel Jacksonville	No.	80%
Escambia	J. M. Hoffman, M.D., Pensacola.	2nd Tuesday	8:00 P.M.	Board of Health Building Pensacola	No.	68%
Hillsboro	John S. Helms, Jr., M.D., Tampa.	1st Tuesday	8:00 P.M.	Tampa Municipal Hospital Tampa	No.	100%
Jackson	Lewis Pierce, M.D., Marianna.	2nd Tuesday	7:30 P.M.	Hotel Chipola, Marianna	Yes.	91%
Lake	W. L. Ashton, M.D., Umatilla.	1st Thursday	12:30 P.M.	Eustis	Yes.	94%
Lee	Robley D. Newton, M.D., Ft. Myers.	3rd Friday	7:30 P.M.	Lee Memorial Hospital Ft. Myers	No.	100%
Leon-Gadsden-Liberty-Wakulla-Jefferson	O. G. Kendrick, M.D., Tallahassee.	Quarterly	3:00 P.M.	Varies	Yes.	100%
Madison	Geo. O. Davis, M.D., Madison.					100%
Manatee	W. D. Sugg, M.D., Bradenton.	3rd Tuesday	7:00 P.M.	Whitfield Country Club Bradenton	Yes.	100%
Marion	Richard C. Cumming, M.D., Ocala.	3rd Thursday	12:30 P.M.	Marion Hotel Ocala	Yes.	95%
Monroe	W. R. Warren, M.D., Key West.	1st Sunday	9:00 P.M.	Varies	Yes.	100%
Orange	John A. Pines, M.D., Orlando.	3rd Wednesday	8:30 P.M.	Varies	No.	100%
Palm Beach	R. Henry Baldwin, M.D., W. Palm Beach.	4th Monday	8:00 P.M.	Good Samaritan Hospital W. Palm Beach	No.	100%
Pasco-Hernando-Citrus	Geo. R. Creekmore, M.D., Brooksville.	2nd Thursday	7:00 P.M.	Varies	Yes.	100%
Pinellas	O. O. Feaster, M.D., St. Petersburg	1st Friday	8:00 P.M.	Assembly Room, 5th floor, P. & L. Bldg. St. Petersburg	No.	100%
Polk	J. R. Boulware, Jr., M.D., Lakeland.	2nd Wednesday in Feb., Apr., June, Aug., Oct., Dec.	1:00 P.M.	Lakeland	Yes.	94%
Putnam	E. W. Warren, M.D., Palatka.	2nd Thursday	7:00 P.M.	James Hotel, Palatka	Yes.	100%
St. Johns	Reddin Britt, M.D., St. Augustine.	3rd Tuesday	8:30 P.M.	Varies	Yes.	100%
St. Lucie-Okeechobee-Indian River-Martin	J. D. Parker, M.D., Stuart.	3rd Thursday	8:00 P.M.	Varies	Yes.	92%
Sarasota	J. E. Harris, M.D., Sarasota.	2nd Tuesday	8:30 P.M.	Varies	Occasionally.	100%
Seminole	J. T. Denton, M.D., Sanford.	2nd Monday	7:00 P.M.	City Hospital Sanford	Yes.	100%
Sumter	W. E. Mitchell, M.D., Coleman.	2nd Tuesday		Varies	No.	100%
Taylor	C. A. O'Quinn, M.D., Perry.	Last Friday	8:00 P.M.	Dixie-Taylor Hotel Perry	Yes.	100%
Volusia	Joseph H. Rutter, M.D., Daytona Beach.	2nd Tuesday	7:30 P.M.	Varies	Yes.	97%
Walton-Okaloosa	A. G. Williams, M.D., Lakewood.	3rd Thursday	8:00 P.M.	Varies	Occasionally.	100%

NOTE—Secretaries: Please submit information to complete the above schedule.



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NEXT SESSIONS Florida Medical Association, Ocala, 1935.
Southern Medical Association, San Antonio, November 13-16, 1934.

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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
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FRACTURES IN THE REGION OF THE ELBOW*

ARTHUR H. WEILAND, M.D.,
Coral Gables.

Fractures in the region of the elbow and their care comprise one of the most important phases of traumatic surgery. Second only in frequency to wrist fractures there is no part of the bony skeleton in which injury is followed more frequently by some interference with normal function. Due to the fact that a great many of these injuries occur in the working class any resultant permanent disability becomes a serious economic loss.

The fact that three separate and distinct bones are involved in the construction of the elbow joint accounts for a multitudinous array of fractures. Certain anatomical considerations are important to the complete realization of this subject. The shaft of the humerus broadens in its lower third and the lateral and mesial borders flare out sharply to form the condyles. On each condyle there is a sharp projecting knob called the epicondyle. The one on the mesial side is much more prominent than that on the lateral side and is grooved behind for the ulnar nerve. The mesial condyle is larger than the lateral and is called the trochlea. It articulates with the sigmoid cavity in the olecranon process of the ulna. The smaller lateral condyle is the capitellum and articulates with the head of the radius. On the anterior face of the humerus just above the trochlea is a depression called the coronoid fossa which receives the coronoid process in flexion. Posteriorly at about the same level is the olecranon fossa which receives in complete extension the olecranon process. At this point the bone is very thin and constitutes an important predisposition to fracture. The head of the radius presents a constricted cylindrical appearance and is held firmly in apposition to both the ulna and humerus with which it articulates by means of the orbicular ligament. The angle formed at the elbow, when in complete extension, is approximately 165 degrees with the angle open outward and is called the carrying angle. At birth the lower end of the humerus is cartilaginous and complete ossification does not take place until the eighteenth year. Hence fracture before that age is much more frequent than after ossification is complete. This fact must also be kept in mind in radiological studies of any elbow in which fracture is suspected. In young patients, particularly those before the age of ten, x-ray studies of the elbow are altogether inadequate to make an accurate diagnosis of fracture and a great deal of reliance must be placed on the clinical manifestations accompanying the injury. Moreover not infrequently has an ununited center of ossification been called a fracture. This is particularly true of the capitellum whose centre unites with the shaft about the seventeenth year.

Fractures in the region of the elbow then must be differentiated as follows:

(A) Fractures of the lower end of the humerus.
(B) Fractures of the upper end of the ulna.
(C) Fractures of the upper end of the radius.

Fractures of the lower end of the humerus present several distinct types:

(1) Supracondylar fracture.
(2) Transverse diacondylar fracture.
(3) Fracture of a single condyle.
(4) Intercondyloid or "T" fracture.
(5) Fracture of an epicondyle.
(6) Separation of an epiphysis.

The supracondylar type of fracture is found frequently in children and this together with the diacondylar type is produced by a fall on the outstretched hand with the elbow hyperextended. The characteristic deformity is a backward displacement of the lower fragment. Fracture of a single condyle or epicondyle is usually produced by a direct blow on the elbow. The intercondyloid fracture is essentially an injury in adult life. It is frequently accompanied by considerable comminution and marked displacement of the fragments. It may also be seen not uncommonly in combination with injury to the upper end of the radius and ulna and in such cases is frequently compound. This is the injury usually sustained by motorists to the left elbow when

*Read before the Sixty-first Annual Meeting of the Florida Medical Association, Jacksonville, April 30, May 1 and 2, 1934.

that protruding member is struck by a closely passing vehicle such as the overhang of a truck.

In most fractures of the lower end of the humerus essentially the same treatment is indicated. That is, adequate reduction under anesthesia and fixation in acute flexion. By adequate reduction is meant not just simply putting the arm into acute flexion but actual manipulation to secure the proper relation between the short lower fragment and the upper fragment. Not infrequently the lower fragment remains rotated internally which if allowed to remain not only interferes with complete flexion and extension but impairs the carrying angle. The position of acute flexion has been adequately described by Sir Robert Jones of London. This position splints the fracture and holds the fragments in their corrected position better than any other. The post reduction treatment is extremely important because it alone may determine the extent to which any given injured elbow may recover function. Every case must be treated individually depending on the type and severity of the injury but in general, active exercises are begun on the tenth day and the range of motion gradually increased up to the point of tolerance. Various types of physiotherapy, such as heat, massage, etc., are of great value. Later on when union is firmer weight supporting to stretch the resisting tissues is indicated. For this purpose a pail of sand which can be graduated as to weight makes a convenient article to use. Forcible passive exercises sufficient to tear the tissues and produce hemorrhage is contra-indicated.

In those cases of "T" fracture in which there is a great deal of separation of the fragments or excessive comminution of the articular surface, more radical treatment should be used early following the injury. Here a complete resection of the lower end of the humerus or of the entire elbow joint, where the radius and ulna are also involved, may be done as it promises less disability than under the more conservative treatment. The post operative care in these cases is similar to that employed in resection arthroplasty of the elbow, early motion being started to maintain flexibility of the joint.

Fractures of the the upper end of the ulna comprise:

(1) Fracture of the coronoid process.

(2) Fracture of the olecranon.

Fracture of the coronoid process rarely occurs alone but is the usual accompaniment of a posterior dislocation of the elbow. Reduction is readily obtained by placing the elbow in acute flexion.

Fracture of the olecranon may be produced by a direct blow or a fall on the semiflexed arm. Due in part to the blow and in part to the action of the tense triceps muscle, the tendon of which is attached to the tip of the olecranon, the proximal fragment is oftentimes widely separated from the shaft.

Treatment in this case reverses the position of choice in all other fractures of the elbow inasmuch as complete extension is indicated. If adequate apposition of the fractured surfaces cannot be procured by the closed method, open reduction should be resorted to and the fragments fastened with kangaroo tendon or some other resistant suture.

Fractures of the upper end of the radius may be differentiated into those involving the radial head and those involving the neck. They are much more common in adults than in children and are usually the result of a force transmitted through the shaft of the radius forcing the head against the capitellum. If little or no displacement of the fragments exists, the elbow should be flexed acutely in complete supination. If, however, any degree of displacement, particularly of fragments of the radial head, is present a resection of the head of the radius should be done without delay and active motion established as soon thereafter as cessation of local reaction will permit.

Success in the treatment of fractures about the elbow as well as any other part of the skeleton depends on the observance of certain anatomical and mechanical principles. Failure to observe the characteristic displacements and the mechanics of adequate reduction as well as the principles of post reduction treatment will most certainly lead to disastrous results.

DISCUSSION

Dr. F. L. Fort, Jacksonville:

All of us who treat fractures involving the elbow sooner or later have trouble. They are rather complex and cannot quickly be classified. There are things other than the bony structure that are damaged when fractures involve this joint. Incidentally, I find in my experience that fractures of the elbow are even more common than fractures of the wrist or other joints. In children we see many fractures of the elbow, and supracondylar fractures are by far the most numerous. In the first few hours after the in-

jury occurs reduction is fairly easy, in my opinion. The fractures can be satisfactorily reduced under local anesthesia in the majority of cases.

I think it is worth stressing that where the upper end of the shaft is protruding anteriorly to the joint before the swelling and muscle spasm have occurred, with the assistant making traction on the arm, you can hyperextend and engage the two ends of the fracture, and then with the assistant still making traction, flex the elbow, and reduction is usually very easy.

Now, the position for maintaining reduction: There is a rule that is very satisfactory and which you can go by almost invariably. After having reduced a fracture of the elbow, excepting fracture of the olecranon, it is advisable to keep the elbow in flexion to at least a right angle. I prefer after I know reduction has been completed to flex the elbow less than 90 degrees or around 60 degrees with complete supination of the forearm. That position will maintain fractures in position, excepting fractures of the olecranon.

It is my opinion that every fracture of the olecranon with separation or complete fracture with displacement should have open reduction. I disagree with Dr. Weiland in his statement that complete resection of the bone should be done in "T" or "Y" fractures of the lower end of the humerus immediately after the injury occurs. I feel that even though the injury is a complete one it should be treated conservatively at first, and if necessary later to do a resection, I think an arthroplastic operation preferable.

Compound fractures are becoming more numerous and more severe with automobile accidents. After the debridement operation, which should be done as soon as possible, closed reduction should be attempted. Later if this is not successful, an open reduction should be done. I do not hesitate to go into an elbow joint if there is displacement that will interfere with function.

Complication in the after-care: Ischemic paralysis. This may occur no matter what kind of splint is used, or whether a splint is employed. The patient should be watched very carefully for 24 to 48 hours following reduction. A doctor always gets blamed for ischemic paralysis whether he is responsible for it or not, and he can do something to lessen its severity or even avoid it in practically all cases.

The ulnar nerve is frequently involved in lower end column fractures with displacement, including fractures of the internal condyle. That may occur as long as twenty years after fracture of the elbow. It is an easy thing to correct by transplanting the ulnar nerve from its berth behind the condyle across the front of the elbow joint, thus relieving pressure symptoms on the ulnar nerve.

A PERINEORRHAPHY*

G. H. Edwards, M.D.,
Orlando.

It is with some hesitation that I present to you a paper upon a subject as thoroughly debated as perineorrhaphy. Although many times arguments pro and con seems to make a subject the more obscure to the listener, yet like each argurer, who thoroughly believes he possesses the solution, I too feel that in certain selected cases no repair is quite as good as my time election type, if you will permit me to so term it.

I hesitate first because as yet I have so few cases—only eighteen—in which operation took place over a year ago. This small number is due to the many factors which enter into the selection of a case for this period of repair. However, the uniformly good results I have obtained have impelled me to make a report now, rather than to wait until I have a more imposing number.

Second, I am not sure that this is the proper place to make this report, as the operation is distinctly one for a hospital and has no place in the bag of a physician who is attending a patient in the home. Since the majority of babies are born in the home, this idea of mine will interest only those who conduct their deliveries in a hospital.

There has been confusion in my mind as to whether I should term this suturing of the perineum, as I do it in certain selected cases, an immediate or a secondary repair, for it is both; that is, an immediate repair of a perineum recently lacerated, and at the same time, a building up of a relaxed insufficient perineum, the result of a previous laceration, which had not been repaired or which having been closed, due to some mischance, (as infection, tearing out of sutures, early absorption of sutures, badly traumatized perineum or poor technique) has failed to give satisfaction.

I believe my attention was first especially at-

*Read before the Sixty-first Annual Meeting of the Florida Medical Association, Jacksonville, April 30, May 1 and 2, 1934.

tracted to the amount of time lost to women, because of pregnancies and perineorrhaphies, by a patient of mine some five years ago, who voiced herself quite authoritatively on the subject of the high cost of medical and hospital care. Besides this loss of time factor, several others might be noted which are favorable to a perineorrhaphy at this time: No matter how simple and short an operation, there is always a hazard, if it means the imposing of another anesthetic upon the woman; expense conservation is being increasingly considered by our patients. An extra ten days hospital bill and for part of that time, the cost of a nurse and possibly the employment of extra help in the home would be saved for the family. Further, the physician would probably lose part of his customary fee for the operation, which is rather hard as he is many times underremunerated. Another factor is the opportunity of early placing of the perineal parts in a normal relationship. With these things in mind, it would obviously seem that this is the time to do the work.

On the other hand there are also factors to be considered; the danger of infection which is of moment, but is guarded against by the care in selection; second, some difficulty may be experienced in identifying the parts due to their unusual relaxation and possibly some slight edema; and, third, a certain added strain is placed upon the woman to which of course she should not be subjected unless all factors are favorable.

Like the majority of therapeutic surgical procedures from our standpoint, the perineorrhaphy is of comparatively recent date. The loss of a perineum is such a tremendous handicap to a woman, that one would expect it to have attracted the attention of the doctor-priest or priest-doctor and that in ancient records on clay or stone some treatment or rite could be seen today. A few years ago I had an opportunity to examine several thousand pieces of pottery with Mr. Wm. C. Hill, a well-known archeologist working in ancient Corinth, and we failed to discover a single record of this nature, although many curious treatments, probably of religious nature, of our differentiating sex features were depicted. In the wonderful unearthing today of pottery and stones showing ancient modes of living, worship and culture some treatment of the perineum may yet appear.

Ambrose Pare, writing about 1582, is generally credited with having been the father of the repair, although tradition states that in the eleventh century a cure was obtained by operation. There are few references to operations in this field until between the years 1820 and 1850, when many men in western Europe, and a few in the United States, began to publish records of successful operations both for complete and incomplete lacerations. But to Emmett in 1883 goes the credit of a careful anatomical study of the region and a demonstration of the part the torn muscles and fascia played in the loss of support of the sacral segments in the pelvic floor.

With the knowledge we have today of the work done in the first portion of the 19th century, it is indeed surprising to find in a textbook on obstetrics published in 1861 by Dr. C. A. Meigs, Professor of Obstetrics, Jefferson Medical College, in a lecture on lacerations of the perineum: "Sutures only add to the sum total of the local injury and are not unapt to generate an erysepelatous propensity in the parts." In speaking of a laceration into the rectum, he says: "It offers no hope of remedy and renders the creature an object of pity to others and an aversion to her own conscious self." Also Dr. Wm. Tyler Smith of St. Mary's College, London, in 1857 devotes page after page to the protection of the perineum against tearing, but not a word is offered about repairing the laceration he so openly dreads and which he, many a time, must have noted. Both of these textbooks by outstanding men of their day are in my father's medical library and are concrete evidence of the slow progress made by new ideas and activities during those years, due either to what we would consider poor methods of communication or else to a local feeling that nothing good could arise elsewhere; a complacency which has always retarded progress and is well expressed in the biblical phrase "Can any good thing come out of Nazareth?"

Even as late as 1889 Dr. W. T. Lusk, Professor of Obstetrics and Diseases of Women, Bellevue Medical College, in his textbook, "The Science and Art of Midwifery," states: "Lacerations, unless they go deeply into the body of the perineum, might better be left to granulate up." This is something which today we never think of doing. Also, about 1880, a Dr. Jewett, quite a famous obstetrician in my home state, stated one should "never try to sew up a perineum, as God had some purpose when he permitted it to be torn." So in that locality, this keystone when once rent limited a woman's activities, home,

social and athletic to an extent depending upon the degree of the damage.

I may mention a number of factors which have to be considered before the operation is decided upon. The first is a laceration in a perineum which has been damaged at a previous delivery and needs to be rebuilt. In this series, whether the opening was large and the perineum appeared narrow, played no part of itself in election for operation, for many an apparently insufficient perineum supports the possessor well. Only those cases were operated upon in which, in addition to a visably small and palpably weak perineum, the individual complained of a sense of loss of support or weight in the pelvis, usually accompanied by backache and a discomfort as though her pelvic organs were being pushed out when straining at stool. Second, a vaginal tract should be free or nearly so of a discharge. Third, a vagina with the mucosa reddened and which has needed prepartum care is not to be looked upon with favor. Fourth, the perineum should not have been subjected to prolonged pressure during delivery, whether it shows any contusion or not. Fifth, the history of many pre-delivery examinations or intra-vaginal manipulations is dissuading. Sixth, any marked edema of the perineum is barring. Seventh, contusions of the perineum renders a good result less likely. Eighth, no undue uterine hemorrhages should present, that is beyond that which may be well controlled by vaginal tampon. Ninth, the patient should be in good condition, able to stand the added strain which even this minor operation imposes.

Most of us after years of work have gradually built up a technique and method of approach, which seems to each one of us more elastic, and more rational than all the others; at least, it seems better to fit in with our ideas of a proper execution. Often it is a modification of, or a combination of, several features from standard types as laid down by those whom we are prone to think of as masters. Most of these types, the older described as well as yours or mine, are evolutionary, and ours, or some feature thereof, in a few years may be accepted as standard.

In describing somewhat in detail the method used, I am not giving anything new in this line save in the time factor and this really is not strictly new, as I know that some few men have more recently elected the time of childbirth for the forming of a new perineum. This is not generally practiced and I believe rightly so, unless the perineum has sustained a new laceration at the time; then, the tissues of the perineum having been opened and exposed to infection, it is but a short step, if needed, to enlarge this tear and properly build up the perineal body. We must admit that there is a gamble in it, yet the odds, if care in selection is exercised, are generally in favor of both physician and patient. And is not life to us a gamble? If an acute illness in childhood or an accident in midlife does not carry us off, hypertension, nephritis or coronary artery disease will surely get us later.

In the first place we have a perineum which has once been torn and either united naturally or has been repaired with an unsatisfactory result. This perineum has again been lacerated and presents all the factors which are satisfactory for this time type of repair, that is, the labor has been rapid; there has been no contusion from the use of instruments; little edema of the parts; no history of unusual vaginal irritation before delivery; a uterus that is firm and presents but little hemorrhage. Usually this operation is performed after the delivery of the placenta, although the parts now are so soft and elastic that in order to save time the procedure may be carried out before expulsion.

The upper vagina is well packed with gauze to prevent the bloody uterine discharge from contaminating or obscuring the field and the lower vagina and perineum are again prepared, using one's favorite antiseptic solution. On either side, from the laceration, an incision is made into the muco-cutaneous border extending outward to a point of election. A flap of the vaginal mucosa is now dissected up, carefully, to avoid any buttonholing, which in the presence of the scar of the previous laceration may easily result. This dissection should extend above the point where the levator ani fibers first meet in the recto vaginal septum. The vaginal flap is not only held at its edge by Allis clamps, so as to inflict little contusion, but is also steadied by the fingers of the hand holding the clamp and a very thin flap attempted by the use of scissors and gauze on the fingers of the right or left hand, depending upon the preference of the operator. The structures are exposed and identified by careful scissor dissection and gauze pressure. Whether the fascia of the levator ani is split or not makes little difference, the object being to pick up the muscular bands, preferably with the

fascia and bring them together in firm approximation. The tenaculi grasp these muscle or fascial edges at the points of election and a No. 2 chromic is passed deeply into them making a figure of eight suture, after the technique of Gerry Holden, save that the suture does not embrace the skin, or several interrupted sutures may be placed. One interrupted suture or figure of eight is placed high above the point of the usual appearance of a rectocele, so as to prevent any chance of the rectum bulging into the vagina. A continuous chromic is now passed back and forth from one side to the other taking deep bites of the perineal tissue, drawing it firmly together and building up a thick heavy new perineum. At first I used two to four mattress sutures, but I feel that the continuous suture is preferable, as it is more quickly placed and there are fewer chromic knots. Usually a portion of the redundant vaginal flap is excised and a continuous No. 1 chromic is placed in the mucosa beginning at the upper angle, every second bite taking up a portion of the newly acquired perineal body, so as to prevent any dead space and is tied at the former muco-cutaneous margin. One silk worm gut suture, rarely a second, is now inserted deeply into the face of the perineum, one-third inch from the edge of the incision entirely surrounding the mass of tissue held by chromic gut sutures and, coming out on the opposite side again one-third inch from the edge, a single knot of four or five turns placing a bar across the suture line is tied judiciously, so when the patient is again in the recumbent position, there would not be pressure enough to cut into the skin of the perineum. Also to prevent inversion of the skin edges, these are now picked up and approximated by two, three or four metal clips, the number depending upon the length of the suture line and tendency of the edges to invert. The clips may be removed in five to seven days, while the silk worm gut, unless it happens to be tied a bit too tightly and cuts into the tissue, may remain seven to ten days.

My results have been uniformly good. Since the parts were unduly relaxed and nearly always presented some edema, the foremost thought has been that it was better to overcorrect, yet in only one instance was the opening too small and that at the muco-cutaneous edge. This error was easily corrected by novocaine and a sharp scalpel a few weeks later. In two instances the result was fair only, because of sloughing; one due probably to devitalized tissue, the result of a somewhat prolonged pressure of the head upon the perineum, an episiotomy and low forceps application; in the other the tissue sloughed around the chromic knot. One patient admits some return of her troubles; the other, however, gets good support, although the vaginal opening is somewhat large.

Two others, patients who originally had deep lacerations into the right posterior sulcus, present only a fair perineum to eye and finger, yet both are vastly improved and neither complains of any of her previous discomfort in the back and pelvis, though the openings might have been made a bit smaller.

Two more would have looked better if the face of the perineum had been built up a bit higher. Possibly the fear of over-correction or the presence of some edema or greater relaxation than was realized, led to the error; however the support afforded is excellent.

Three of these patients have since been delivered by me of another child. In two of these cases a median episiotomy was done and one child lifted out with forceps. The repair by mattress chromic No. 2 with one silk worm gut and two clips gave a good result. The third was delivered by low forceps, but while no laceration presented, the perineum today is rather thin and there is some return of her old sense of loss of support.

To recapitulate, two, which is 11%, have had some recurrence of the old sense of loss of support, one, however, after a succeeding child, as noted above. Five, which is 28%, get good support, but the openings might have been made a bit smaller. Eleven, or 61%, present good to excellent results both to eye, finger and patient. If you will combine the last two classes, that is those which gave relief to the suffering patient, even if the eye of the artist or anatomist be offended, we have 16 cases or, 89%, of cures; a percentage which does not compare unfavorably with repairs done at a time which is generally considered proper.

DISCUSSION

Dr. Gerry R. Holden, Jacksonville:

We have learned from experience that whenever Dr. Edwards tells us anything we always learn something interesting, something original. I am glad to say that this time is no exception.

The repair of the perineum at the time of labor is something with which I am personally not familiar. I do not do obstetrics, but I have repaired many perineums months or years after the original laceration. And I have frequently

wondered why the obstetrician at the time of labor did not do the same thing which I did months later. I am glad to hear from Dr. Edwards that it is a feasible proposition. On the face of it, it seems that there is no reason why one should not enlarge the incision which nature has made just a little bit, get hold of the muscles, bring them together, suture them as he describes, and let the woman go on her way rejoicing.

There are, I believe, two prime considerations. The first is the approximation of the muscles, and second, the obliteration of dead space.

As Dr. Edwards says, Emmett in this country in 1883 was about the first man to bring this proposition before the profession in his famous, so-called "Butterfly" operation. Dr. Emmett did not recognize the value of the muscles. He spoke only of the fascia covering the muscles. As a matter of fact his suture did include the muscles but he did not mention them by name.

Years later, Dr. Noble, of Philadelphia realized the importance of the levator ani muscle. He stated that if the repair is to succeed the levator ani muscle must be included in the repair work.

It makes no difference really what form of incision is used as long as the muscles themselves are approximated. A fairly good cosmetic result obtained by bringing the fascia together in an esthetic manner, and you will get a good perineum if the second principle is adhered to, the obliteration of dead space.

I certainly think that Dr. Edwards should be congratulated for bringing out the advisability of doing these few simple procedures immediately after a labor.

Dr. W. M. Rowlett, Tampa:

I wish to congratulate Dr. Edwards on his splendid paper; he has presented some very interesting data. The history of perineorrhaphy dates back to the eleventh century. From then to the present time, nearly a thousand years, a multitude of illustrious surgeons have linked their names with one or another phase of this yet incomprehensive gynecological procedure. I am convinced that there is no section of surgery that possesses so much rubbish as expressed in the numerous theories that have been advanced regarding the secondary repair of the lacerated perineum. I consider that any extensive laceration or relaxation of the perineal muscles sufficient indications for doing a perineorrhaphy. The treatment consists of primary, intermediate and secondary repair. The proper conduct of one's maternity work should reduce them all to the primary class. I make it a rule to keep all of my obstetrical cases under observation for a year after delivery. From these observations I have learned many things that I could not find in the books or journals. For a long time I had an egotistical idea that I possessed an unusual ability for preserving the perineum of the primiparae. After several years of follow-up observations, I discovered that while there were no skin or vaginal mucous membrane tears, the muscles beneath had many times separated, producing a great deal of relaxation and the accompanying complications.

Dr. Edwards spoke of episiotomies. For the last nine or ten years I have changed my technique of delivery and am doing an episiotomy on practically all primiparae. The results have been nearly a hundred per cent improvement. The episiotomy should be done after getting a moderate amount of dilatation of the levator. I do not believe it is wise to wait until the muscles are all contorted and giving away of the musculofibrous sling. The incision of choice is a left mediolateral. Before making the incision, I inject a one per cent novocaine solution along the expected line, thus eliminating the necessity of an anesthetic. You understand that all of my obstetrical work is done in the hospital which I realize gives me a great advantage over those of you who are compelled to do home deliveries. During the past several years I have corrected a good many old incomplete perineal lacerations at the time of delivery with good success, and can see nothing against it where you have a good risk and the patient in the hospital.

My choice of the perineoplasty is only slightly modified from the technique described by Dr. Edwards. A perineal retractor is caught on each side of the vagina at the caruncles which mark the openings of Bartholin's glands. Great care should be taken so as not to injure the gland or duct. With a little traction the mucocutaneous border is well exposed, the incision made just inside the border extending up each side to where retractor is caught. After resecting back the flap exposing the underlying tissues, I proceed to identify and reconstruct the musculo-fibrous sling, using an interrupted chromic cat gut No. 1. After this I close the external wound with an interrupted suture of chromic cat gut or more often a subcuticular stitch. I have never used silkworm gut or metal clips.

Dr. G. H. Edwards, Orlando (concluding):

I want to thank these two men for discussing the paper. I think that Dr. Holden remarked that the repair not being properly done is not entirely due to the physician. You must remember that most of our primiparae have suffered from a long delivery. If you wait for a long time and then do an episiotomy or if you wait for a natural delivery and have a perineum which is edematous, your repair due to the devitalized tissue may not be as satisfactory as if you had followed Rowlett's idea by doing an early episiotomy.

I find one physician here who tells me that he also is doing similar work; possibly many of you are doing the same thing, but it has not been published or if so has failed to come to my attention.

THE PREVENTION OF PUERPERAL INFECTION*

L. L. Dozier, M.D.,
Tallahassee.

DeLee defines puerperal infection as a general term embracing all the conditions, usually of a febrile nature, but sometimes non-febrile, affecting puerparae, originating from infection of the genital tract at any point of its extent.

The disease has been known for centuries. Hippocrates wrote an accurate description of it and mentioned epidemics of the fever. It was not until the nineteenth century, however, that its contagious nature was appreciated.

In 1847 Semmelweis offered the theory that puerperal infection was a resorption fever brought about by the introduction of animal matter into the genitals by means of the accoucher's fingers, the instruments, douche nozzles or anything which could transport the decomposed animal matter from its source to the parturient canal.

In 1843 Oliver Wendell Holmes presented a paper entitled "The Contagiousness of Puerperal Fever" in which he proved that the infection was carried from one patient to another as a contagion.

In 1880 Pasteur cultivated streptococci from a fatal case of puerperal infection. Since that time the bacterial nature of the disease has been proved conclusively. This fact together with the introduction of aseptic technic in obstetrics would lead one to believe that infection is no longer a serious problem in childbirth.

Reliable statistics indicate that of the more than two million full term pregnancies occurring in this country annually, nearly 25,000 of the mothers die. More than 40% of the deaths are due to infections. For every patient who dies there are probably ten who are more or less seriously ill, so that annually the puerperal morbidity in this country totals more than 200,000, almost half of which are due to infection.

Preventive medicine has done much to lower the death rate in contagious diseases such as tuberculosis, typhoid fever, diphtheria and many others but it has had practically no effect in lowering the death rate from conditions incident to pregnancy and childbirth. The mortality from sepsis has remained almost stationary for the last fifteen or twenty years.

Many bacteria have been held responsible for puerperal infection but it has been proved by bacteriological study that the hemolytic streptococcus is responsible for the majority of cases of the disease.

There are several possible ways by which the bacteria may gain entrance to the birth canal. Undoubtedly the cervix and vagina harbor streptococci and other organisms but they live a saphrophytic existence and are rarely responsible for serious infection.

Another possible source is the hematogenous route from foci of infections such as tonsillitis, sinusitis, otitis, abscess of the breast and others.

A small number of women are infected by coitus immediately before labor. Some are infected by manipulating the genitalia during labor and the puerperium.

The vast majority of cases, probably 99%, are caused by the organisms being introduced into the birth canal during labor. Therefore our methods of the conduct of labor must be responsible for practically all cases of the infection.

If this is true what can be done to remedy the condition?

First let us examine our attitude toward the conduct of labor. Do we have the same respect for the birth canal of a woman in labor that we have for the peritoneal cavity? Do we practice the same aseptic technic before invading the parturient vagina that we practice before invading the peritoneal cavity? Do we realize that the freshly delivered uterus offers an ideal soil for the growth of bacteria of all the varieties and

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that any pathogenic organism introduced into the vagina at the time of labor will grow and give rise to infection? In other words do we appreciate the danger in making unnecessary vaginal examinations and the danger of doing operations of convenience for the sake of speed in delivery?

The prevention of infection should begin as soon as the patient learns that she is pregnant. She should place herself in the hands of a physician for prenatal care and the value of prenatal care cannot be minimized. Every patient should be seen at regular and not too infrequent intervals during pregnancy. She should have a complete physical examination at the first visit and thereafter her blood pressure, weight and kidneys should be closely watched for signs of beginning toxemia. She should be instructed as to her diet and exercise for it has been shown that a woman who gains excessively during pregnancy is much more likely to have some complication of pregnancy than one whose weight gain has not been excessive.

The proper conduct of the first stage of labor plays an important part in the prevention of infection. If the patient has gone through this stage without exhaustion her chances of spontaneous delivery are much greater than if she has been allowed to wear herself out because of lack of rest and sleep which might have been secured by the judicious use of drugs.

Her chances of infection are greatly lessened if a vaginal examination has not been made during the first stage of labor. The majority of maternity cases are cared for by the general practitioner and most of them are delivered in the home, many under adverse conditions and without adequate assistance. It is frequently necessary for the physician to be both physician and nurse in a labor case and carry on his other routine work at the same time. This makes it imperative that he accurately know the progress of labor at every visit he makes. It is not possible for him to sit by the patient throughout the first stage of labor so it is necessary that some kind of examination be made which will give him the information he requires. This information can be gotten by rectal examination without fear of infecting the patient. By such an examination it is possible to determine the degree of effacement and dilatation of the cervix, the descent of the presenting part, to determine what part is presenting and in most cases to outline the cranial sutures and differentiate between occipito-anterior and occipito-posterior positions. This information together with that which may be gained from a careful abdominal examination is all that is necessary in the average case. A rectal examination can be safely made without preparation of the patient. All that is necessary is a rubber glove and lubricant. The examination is practically painless because during labor the sphincter ani and levator ani soften and become more dilatable. After the head engages in the pelvis the sphincter relaxes readily under pressure and later in labor the anus is patulous.

It is doubtful if a vaginal examination during labor can be made with assurance that infection will not take place. We do not have any chemical antiseptics which will absolutely sterilize the vulva and vagina without injury to these structures.

In the second stage of labor a spontaneous delivery is the goal toward which the physician should work. Every opportunity should be given the patient to deliver without interference. In occipito posterior positions she should be given drugs to secure rest. Sufficient time should be given nature to accomplish rotation of the head for nature is much more skillful in doing this than is the hasty physician. Operative interference should not be indulged in as long as the condition of the mother and child are good and spontaneous delivery is possible.

In recent years there has been a trend toward radicalism in obstetrics. Particularly is this true where hospital facilities are at hand. In some hospitals forceps delivery is almost a routine procedure and operative interference is resorted to on the slightest provocation. All this interference increases the chances of infection.

One of the greatest needs in obstetrics is a return to the idea that childbirth is essentially a physiologic process which should be interfered with only for a good and definite reason. It is hoped that some day the public will realize the fact that frequently a spontaneous delivery calls for more skill, knowledge and judgment than does operative intervention.

Let us be reminded that nature intended for a woman to deliver herself without assistance, and that the vast majority of women will deliver spontaneously if given time and a little help in the form of pain-easing drugs and that in at least four cases out of five it is unnecessary for us to subject her to the possibility of infection by doing unnecessary vaginal examinations.

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TO STUDY CONCEPTION AND THERAPEUTIC AND EUGENIC STERILIZATION

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THE DENGUE FEVER SITUATION

For many years the medical profession has felt a sense of security against certain tropical diseases which almost amounted to a belief that they will never again appear in the United States. Health officers also have taken the attitude that one need have no fear of yellow fever, pointing to the fact that the last outbreak in the United States occurred in 1905. We must not overlook the fact that, since previous epidemics, a large percentage of the population is non-immune to yellow fever and with general and heavy production of *Aedes aegypti (stegomyia)* one case of yellow fever introduced might mean a serious epidemic.

In 1924-25-26, Siler, Hall and Hitchens, in a series of experiments with soldier volunteers, showed *Aedes aegypti* (formerly known as *stegomyia)* the most important carrier of dengue. *Aedes albopictus,* a closely related species, is, in the Philippines, also a carrier but, fortunately, is not found in the United States. Further work with the *Aedes aegypti* was done in 1930-31 by Major Simmons and associates, confirming the work of Siler, *et al.*

The results of the transmission experiments mentioned above have been put into practical use in Florida during the past two months for the first time in the United States and probably for the first time in the history of the epidemiology of dengue. The epidemic of dengue which appeared in Miami in July (or probably earlier—the latter part of May or June), is the first known epidemic in the United States since the widespread epidemic of 1922. By applying the control methods used for the checking of yellow fever, the State Board of Health, cooperating with the City Boards of Health, hopes to prevent a state-wide epidemic, in fact, to wipe out the disease in a few weeks. The number of cases in Miami have been estimated at between 6,000 and 8,000.

The lesson to be learned is that we are vulnerable to epidemics where mosquitoes are the carriers. In this instance, if the first case of dengue had been one of yellow fever, we might have had an epidemic of yellow fever as extensive as the mosquito *(stegomyia)* production in the various municipalities in the state. By this time there might have been 1,500 to 2,000 deaths from yellow fever.

Physicians should think seriously of the "might have beens" and the ruinous consequences to Florida. Such happenings would divert tourists to other states. It is fully as important to the physician as to the average business man to do his share in correcting conditions which make possible epidemics of dengue or yellow fever. One of the most important safeguards is for all large municipalities to have trained full-time health officers with sanitary officers who have adequate knowledge of mosquitoes and their propagation. Physicians should first fully inform themselves, then inform their patients.

Henry Hanson, M.D.,
State Health Officer.

CORRESPONDENCE

(Editor's Note: *This report from the Chairman of the Committee on State Hospitals for Insane and his communications to the members of the Board of Commissioners of State Institutions are reproduced in order that all members of the Association may be familiar with the splendid efforts of the Committee. The letter from our President, Dr. Pearson, no doubt voices the sentiments of the majority of our members.)*

To the Editor:

I enclose herewith a communication from Mr. J. P. Newell, Secretary Board of Commissioners of State Institutions, to which is attached a copy of the minutes of the meeting of the Board of Commissioners of State Institutions, July 26, 1934, at which Colonel Preston Ayers was unanimously appointed as Superintendent Florida

State Hospital, Chattahoochee, at a salary of $300 a month plus living quarters and maintenance.

It will be noted that the meeting was participated in by Hon. Dave Sholtz, Governor; Hon. R. A. Gray, Secretary of State; Hon. Cary D. Landis, Attorney General; Hon. J. M. Lee, State Comptroller; Hon. W. V. Knott, State Treasurer; Hon. W. S. Cawthon, State Superintendent of Public Instruction, and Hon. Nathan Mayo, Commissioner of Agriculture. In brief, it appears that the entire Board was present and unanimously disregarded the recommendation of the Florida Medical Association and appointed a lay-superintendent, said superintendent having no previous hospital experience of any kind whatsoever so far as is known.

You will also note a communication from the National Committee for Mental Hygiene, 50 West 50th Street, New York City, over the signature of H. Edmund Bullis, Executive Officer, in which it is indicated that there are approximately one hundred and seventy-five state hospitals for mental cases in the United States and that there is only one instance, other than in Florida, in the whole United States of a lay-superintendent serving as the superintendent of a state mental hospital. That is the case of the Hastings State Asylum in Minnesota, where the superintendent is Mr. William Y. Yanz.

It is peculiarly significant to note the statement of the National Committee for Mental Hygiene expressing as their viewpoint "the prime function of a mental hospital should be to restore patients to mental health and to return them to normal lives in the community. We have always felt that a well-trained psychiatrist is best equipped to determine and administrate the policies of a mental hospital. Where mere custodial care is afforded the value of such a trained superintendent is, of course, of less moment." It is suspected that the Florida State Hospital will be looked upon as more of a custodial institution as it is now under the direction of a lay-superintendent in spite of the protests of the medical profession of this state.

I am sending a copy of this communication to the members of our State Hospital committee—Doctor George M. Dawson, West Palm Beach, Doctor H. A. Day, Orlando, and Doctor H. Mason Smith, Tampa. I am also sending a copy to President Pearson, Miami, and a copy to Doctor W. H. Spiers, a former member of the state hospital staff, now practicing in Orlando.

It is requested that you get up the complete file and submit the same to the President, Dr. Homer L. Pearson, Doctor Dawson, Doctor Day and Doctor Smith for comment. It would be my recommendation that the whole transaction not only be published in the State Medical Journal but that it be reduced to a personal communication to every member of the Florida Medical Association, to be mailed in an individual envelope. If it is decided that we shall not calmly accept the definite rebuke of the Board of Commissioners of State Institutions, I would recommend that each county medical society be requested to make the matter one of a discussion in an open meeting for such action as the individual county medical societies and the members thereof may deem appropriate. I feel that this final expression should be consolidated and placed in the hands of the Board of Commissioners of State Institutions consisting of the Governor and his cabinet members.

So far as I know this is the first instance of the State Medical Association having made a demand upon the Board of Commissioners of State Institutions. Certainly we have been disregarded in our wishes in a matter pertaining to the greatest hospital in the state in a completely unanimous manner as evidenced by the official vote of said Board.

The State Hospital has been a much abused institution in which surgery has been over-emphasized and psychiatry neglected. Many citizens from surrounding counties have been treated as private medical and surgical cases in the institution, and even members of the families of the state officials at Tallahassee have been treated there, all of which has created a definite instrument of competition to the private practitioners in the state of Florida.

Approximately eight out of the last nine or ten doctors who have been appointed on the state hospital staff have been from the ranks of the medical profession of states other than Florida, Florida doctors apparently having been given no consideration. This is a matter that has been brought to the attention of the Board of Commissioners of State Institutions.

With this communication I will have completed the special detail assigned me by the President of the State Medical Association, but I

assure you that I shall be glad to pursue the correspondence further if directed to do so.

Awaiting your further advices, I am

Sincerely yours,

(Signed) Ralph Greene, M. D., Chairman,
Committee on State Hospitals for Insane.

Extract From Minutes Board of Commissioners of State Institutions

Tallahassee, Florida,
July 26, 1934.

The Board of Commissioners of State Institutions met this day in the executive office with the Governor, Secretary of State, Attorney General, Comptroller, State Treasurer, Superintendent of Public Instruction, and Commissioner of Agriculture present.

The minutes of the last meeting were read and approved.

FLORIDA STATE HOSPITAL

Superintendent—Appointment of Colonel Preston Ayers.

After thoroughly considering the application for the position of Superintendent of Florida State Hospital, motion was made and unanimously adopted appointing Colonel Preston Ayers, effective August 1st, 1934, and fixing his salary at $300.00 per month plus living quarters and maintenance.

* * * * * * *

The Board then adjourned, subject to call.

The National Committee for Mental Hygiene
50 West 50th Street
New York City

August 23, 1934.

Dr. Ralph Greene,
1022 Park Street,
Jacksonville, Florida.

Dear Dr. Greene:

In reply to your letter of August 20, I wish to advise you that our records show that there is only one instance, other than in Florida, in the United States of a layman's serving as superintendent of a state mental hospital. That is in the case of the Hastings State Asylum in Minnesota, where the superintendent is a Mr. William Y. Yanz.

Insofar as our viewpoint is that the prime function of a mental hospital should be to restore patients to mental health and to return them to normal lives in the community we have always felt that a well-trained psychiatrist is best equipped to determine and administrate the policies of a mental hospital. Where mere custodial care is afforded the value of such a trained superintendent is, of course, of less moment.

I am enclosing a complete list of state institutions for mental diseases and their superintendents for your record.

Sincerely yours,
(Signed) H. Edmund Bullis,
Executive Officer.

July 14th, 1934.

Hon. David Sholtz, Governor,
Tallahassee, Florida.

Hon. Cary D. Landis, Attorney General,
Tallahassee, Florida.

Hon. J. M. Lee, Comptroller,
Tallahassee, Florida.

Hon. Nathan Mayo, Commissioner of Agriculture,
Tallahassee, Florida.

Hon. W. S. Cawthon, Superintendent Public Instruction,
Tallahassee, Florida.

Hon. W. V. Knott, Treasurer,
Tallahassee, Florida.

At the last meeting of the Florida State Medical Association a resolution was introduced, which, in behalf of the medical profession of this state, protests against the appointment of a lay-superintendent at the Florida State Hospital at Chattahoochee. This protestation is merely in support of accepted state institutional practices all over the United States, and is confirmed by the report of the special representative of the National Committee for Mental Hygiene, who recently surveyed and reported conditions at Chattahoochee.

It is my information, from the President of the Florida State Medical Association, Doctor Homer L. Pearson, that I am to be the chairman of a special committee to advocate, at the proper time in the future, the establishment of another state hospital in some central location in the peninsula of Florida.

Recent developments seem to indicate that the Board of Commissioners of State Institutions has tendered the superintendency of the state hospital to at least one layman. Telegraphic protests have doubtless been filed by secretaries of county medical societies all over this state. The hope is still entertained that a competent doctor

will be placed at the head of the institution. Surely the largest hospital in the state, with a patient population of four thousand, is entitled to the administrative ability of a competent doctor. There can be no successful program under the control of two directing heads. The idea of having a lay-superintendent to handle the business affairs and a doctor to handle the medical affairs can only result in the medical staff having to contend always with the difficulties of converting a lay-superintendent to a medical viewpoint. The undersigned has definite, tragic recollection of having medical opinions overruled time and time again by lay-superintendents who, while acting in good faith, knew not that of which they spoke. The undersigned has had to request permission from lay-superintendents to operate on a given case. At staff meetings in the past lay-superintendents have overruled the entire medical staff in a recommendation for the retention or discharge of a patient. Thus a layman, in face of competent medical opinion, assumed the perogative of final medical judgement. I have recollection of having, on one occasion, recommended a more balanced diet, because of the incidence of a widespread epidemic of pellagra, and was then and there informed that the diet was satisfactory because it compared favorably with the food soldiers received in the final hours of a great civil war.

In selecting a layman for superintendent it is my understanding that it is contemplated to pay him the limit of the salary now allowed by the state. That salary would employ a competent doctor and thus add to a tragically small medical staff at least one more medical mind.

The hospital beds in Jacksonville number approximately four hundred. There are fifteen or twenty internes in service in these hospitals, to say nothing of the two hundred doctors of the city who habitually visit these institutions, attend staff meetings and act in an advisory capacity.

It is said that funds are not available for properly building up the strength of the medical staff at the state hospital. Surely a group of recent graduates in medicine could be secured to act as internes. There is no doubt but that upon proper request the profession of this state would furnish a visiting staff. This visiting staff would serve without compensation. They would not only instruct the young doctors, but would gladly serve in the proper conduct of a psychiatric institute to which the mature members of the medical profession of this state could be invited in order that they might become more enlightened about the subject of treating insane people, and thus afford a distinct economy and a broadening influence in the attitude towards insane people who are, after all, only sick people. As you doubtless know, there are state institutions whose medical staff is numbered by scores instead of a group of eight or ten men who are expected to care for four thousand patients. When any state assumes the responsibility of the custodial treatment of its citizens, and then by force of circumstances subjects these helpless individuals to an unintentional neglect, that circumstance warrants revolutionary measures to bring about a condition which is in keeping with the more widely accepted ideals of the day.

I am fearful that the Board of Commissioners of State Institutions is somewhat in the position of the individual whose experiences are detailed in "Acres of Diamonds." This individual sought riches afar when there was wealth right under his feet.

At Chattahoochee resides Doctor B. F. Barnes. He comes from a distinguished family in Jefferson County. He has not the stigma of having been born north of the Mason and Dixon line. He is not influenced by sentiment or sectional prejudices. He is a business man of outstanding ability. His administrative ability will compare favorably with the administrative ability of any state official, any county official or any banker in this state. He served on the medical staff at the state hospital, along with the undersigned, for a number of years. Indignities that were heaped on his head by the layman under whom he had to work finally forced this public servant, who would doubtless have been willing to devote his professional life to the work at Chattahoochee, back into private practice; a private practice that he had previously given up at the request of the State of Florida in order that he might serve at the state hospital.

I am quite sure that the Honorable Board of Commissioners of State Institutions can secure the services of Doctor Barnes, or the services of a number of other highly trained doctors in this state who are good business men, to occupy the position at Chattahoochee.

I trust that you will realize that this letter is written in behalf of a tragic group of insane people who cannot help themselves, and whose problems I know as the result of the bitter ex-

periences of seven and a half years of work among them. I wish to state, in an impersonal way, that I feel that the superintendency of the hospital while in the hands of laymen has made comparatively less progress and has had a lessened sympathy on the part of the doctors and the people, than while in the hands of the medical men who have acted as superintendents.

I am perfectly willing to agree that the hospital ought to have a layman who can handle business detail, but under the direction of the superintendent and answerable only to the superintendent, and said layman serving without administrative authority, and without hope of ever supplanting the medical superintendent or securing his job. Furthermore, I wish to state that it is a most reprehensible practice to allow the chief engineer, the chief carpenter, the farmer or any other employee of the hospital at Chattahoochee, to take it upon himself to run over to Tallahassee and gossip to the Board about what the superintendent should be doing, is doing or is not doing. The Board should rely implicitly upon the superintendent. The superintendent, if the proper kind of man, will consider the recommendations of the employees under him. Whenever the employees under him go over his head and are allowed to talk to Board members about the administrative affairs of the hospital, the superintendent should then and there discharge the offender and know his action will meet with official approval at Tallahassee. I wish to state that the force and influence of the State Medical Association of Florida is, and will continue to be, dedicated to a program of bringing about a better condition for the delinquent, the defective and the insane of this state.

In behalf of the State Medical Society, and as an individual, I wish to pledge to you and to the Board the cooperation of the best medical minds in this state, provided you will only give them the opportunity of advising with you. If the Board will collectively cease the maintenance of its apparent attitude of assuming that there is no doctor in Florida who has the mental capacity or the ability to handle the superintendency at Chattahoochee, said profession will demonstrate the necessary ability to operate a hospital in a manner conspicuously more efficient than has occurred in the hands of laymen who, because of being politicians, have been given a salary and maintenance to occupy a hospital administrative position without the advantage of previous training and experience in practicing medicine.

With kind personal regards and best wishes,

Respectfully yours,

(Signed) Ralph Greene, M. D., Chairman,
Committee on State Hospitals for Insane.

August 21, 1934.

Honorable R. A. Gray,
Secretary of State,
Tallahassee, Florida.

Dear Mr. Gray:

It was uncommonly good of you to so graciously forgive the inadvertence of not addressing a letter to you along with other members of the Board of Commissioners of State Institutions in behalf of the Florida Medical Association, in the form of a recommendation against the appointment of a lay-superintendent at Chattahoochee.

On the day of Doctor Folmar's death, and in response to an urgent telegram, I flew an airplane through almost completely blind flying conditions to Chattahoochee. On that day Doctor Pound told me that he did not wish to be superintendent for the reason that he felt incapable, because of lack of administrative experience. The doctor added, too, that he preferred to devote his entire time to a strictly professional effort. It must be borne in mind that Doctor Pound is a capable medical man and surgeon, but that he came to Chattahoochee shortly after his medical graduation and was, therefore, probably guided by a self-estimate as to his ability by not wishing to be superintendent at Chattahoochee. The fact that Doctor Pound felt himself incapable of handling this position should not indicate, and I am sure that the Board members would not so believe, that no other physician in the world has the necessary administrative qualifications and experience to successfully direct the program of the affairs of the greatest hospital in Florida.

It is gratifying to know that you have had the inclination at least, if not the determination, to support a medical man's applicancy for the superintendency at Chattahoochee.

I note with interest that which you say about the Executive Secretary of the American Hospital Association telling you that fully one-half of the hospitals in the United States now have laymen as superintendents, and that the trend appears to be in that direction. My reaction to this statement is that there are two factors which

brought about this expression. First, there is a growing tendency on the part of lay people to usurp the authorities and prerogatives of the medical man. This is a matter that the doctors of this country are quite determined to minimize if it is humanly possible for them to do so. The second factor is that there are many very small hospitals in the United States whose financial income and limited operation precludes the possibility of paying a medical man to act as superintendent even though his services might be desirable over that of a layman. In this connection, please let us not lose sight of the fact that we are discussing the matter of a medical man as superintendent of the greatest hospital in Florida; a hospital which is intended for the care of insane. For your information, and in order to place myself in a position to speak authoritatively, I am addressing a communication to the National Committee for Mental Hygiene telling them of the experience here in Florida, and asking them to give me a statement of the number of insane asylums operated by states in the United States, and a statement of the number of these hospitals that have lay-superinendents. I suspect we are going to find that Florida is probably the only one in America that has a lay-superintendent. I may be in error in this latter statement but we will both be informed upon receipt of a reply from the National Committee for Mental Hygiene.

I am addressing a communication to the Secretary of the Board of Commissioners of State Institutions at Tallahassee, requesting that he give me a transcript of the minutes of the meeting at which a lay-superintendent was appointed. I think we are entitled to this information as a matter of public record.

Upon receiving a letter from the National Committee for Mental Hygiene and from the Secretary of the Board of Commissioners of State Institutions I will be in position to report to the president of the Florida Medical Association, Doctor Homer L. Pearson, Miami, Fla., the result of the effort of the special committee appointed to urge the appointment of a doctor as Superintendent at Chattahoochee. It will then rest with the president as to future activities along this line.

I trust you will understand, and that all the Board members, who are my personal friends, will also understand, that this is not a matter that I am indulging in as a personal effort, but an activity which I have been called upon to inaugurate along with other members of the committee, namely, Doctor H. Mason Smith, Tampa, Doctor H. A. Day, Orlando, and Doctor Geo. M. Dawson, West Palm Beach.

I may say also that this same committee has been requested to develop a survey to determine the need for the establishment of another state hospital somewhere in central Florida. I am assuming that the Governor and his present administration would be willing to give consideration to supporting a recommendation of this kind if the needs seem to be indicated by the proposed survey.

During my absence, and under my direction, a letter was addressed to the board members protesting against securing new medical men to fill staff vacancies at Chattahoochee from other states. I attach a copy of this letter as it is apparent that you were also overlooked in this matter, for which oversight I hope you will accept our profound apologies.

With kind personal regards and best wishes, I am

(Signed) RALPH GREENE, M. D., Chairman
Committee on State Hospitals for Insane.

RG-b

August 21, 1934.

Mr. J. P. Newell,
Secretary, Board of Commissioners
of State Institutions,
Tallahassee, Florida.

DEAR SIR:

The undersigned is the Chairman of a special committee appointed by the Florida Medical Association to fulfill two duties. The first was to advocate the appointment of a medical superintendent at Chattahoochee. The second is to conduct a survey to determine the need for an additional state hospital to be located somewhere near an urban center in central Florida.

In the matter of the appointment of a medical superintendent we failed, as indicated by press report under date of July 27th.

As chairman of a special committee from the Florida Medical Association it now becomes my duty to report the whole transaction to the President of the Florida Medical Association, Doctor Homer L. Pearson, Miami, Florida. In order to file a complete and intelligent report it is requested that you furnish me with an official transcript of the minutes of the meeting at which

Colonel Preston Ayres, of Orlando, was appointed the superintendent. It is assumed that this transcript will show the vote of each individual member of the Board of Commissioners of State Institutions. I am assuming there will be no question about our rights in asking for this report, for it is our desire to inform the doctors of the state of the attitude of the different board members in the final issue of the problem under consideration.

At a later date it will be necessary to confer with the Board of Commissioners of State Institutions about the possible need for a second hospital for insane, at which time I shall take the liberty of communicating with you again.

Thanking you in advance for the transcript of the minutes of the meeting as above requested, I am

Respectfully yours,
(Signed) Ralph Greene, M.D., Chairman,
Committee on State Hospitals for Insane.

Florida Medical Association, Inc.
HOMER L. PEARSON, M.D., PRESIDENT
Miami, Florida.

August 4, 1934.

To the Editor of the Florida Medical Journal:

I feel that the doctors of Florida should be acquainted with the facts relative to the appointment of the new superintendent of the State Hospital in Chattahoochee.

During the meeting of the House of Delegates at Jacksonville on the first of May, 1934, Dr. Ralph Greene presented a resolution that read in part as follows:

"Whereas, the history of the institution up to date indicates that all past superintendents, including the present superintendent with three exceptions, have been laymen, and

"Whereas, of all lay-superintendents who have presided over the great medical problems at the said hospital, have assumed charge without previous hospital training of any kind, and,

"Whereas, the policy of selecting lay-superintendents seems to be based upon the idea that a physician would not normally be expected to be possessed of the necessary administrative and business ability to fulfill the position of superintendent at the Florida State Hospital, and,

"Whereas, under the administration of the few doctors who have acted in the capacity of superintendent of said hospital, the real advances in institutional development have been made, and,

"Whereas, conspicuously, and in contrast, little if any true institutional progress has been made under the direction of the lay-superintendents, and,

"Whereas, experience thus far has indicated that lay-superintendents of the past and present have, of necessity, relied upon the advice of the medical personnel serving under them, and,

"Whereas, lay-superintendents throughout the history of the institutional operation, have been inclined to assume the attitude of final judgment, oftentimes contrary to medical advice given them, and,

"Whereas, such attitude on the part of lay-superintendents, unconsciously or otherwise, has the end effect of retarding the medical program, and,

"Whereas, it is a belief that there are competent medical men, with the necessary professional and administrative ability, available from the ranks of Florida doctors,

"Be It Therefore Resolved: That the Florida Medical Association memorialize the Board of Commissioners of State Institutions of Florida, said Board being composed of the Governor of Florida and his cabinet officers, with the urgent recommendation that in the event of future vacancies in the superintendency of the Florida State Hospital said superintendent be selected from the medical profession of Florida, and from the membership of the Florida State Medical Association."

Some six weeks or two months later information came to me that a lay-superintendent was about to be appointed for the state hospital. I immediately wired the Governor, reminding him of the above resolution. A wire was also sent by the Secretary of this Association.

We heard no more about the situation until about three or four weeks ago when Dr. Ralph Greene informed me by telephone that a layman was about to be appointed superintendent. We immediately got busy. Dr. Greene wired the Board of Commissioners and I wired the Board of Commissioners. I also wired the Secretaries of every County Society in the state, asking them in turn to wire Tallahassee of our action in the House of Delegates and that every County Medical Society in the state disapproved the appointment of a layman for this position.

A few days later I noticed in the daily paper that a layman had been appointed over the protest of the doctors of Florida.

These appointments are made by a Board of Commissioners, of which the Governor is the chairman.

While this appointment is not vested in the Governor alone, but in the Board of Commissioners of State Institutions (which, besides the Governor, is composed of the Secretary of State, the Attorney General, the Comptroller, the Commissioner of Agriculture, the Superintendent of Public Instruction and the State Treasurer), it is one which has really been dictated for many years by the Governor.

To my mind this act on the part of the Governor, or the Board of Commissioners of State Institutions, shows us, as nothing else could, the "great respect" held by the powers that be for the wishes of the doctors of this state. Our wishes in this matter were for the good of the unfortunate mental cases of Florida and for the Hospital and was so stated and has been so proved. The Governor's wishes in the matter were to pay a political debt without regard to the man's training for that particular kind of work and without regard for the wishes of a great association of doctors.

We often grow eloquent over the great influence we hold over the people whom we serve. We sometimes boast of our great power—power we never use because we cannot afford to dabble in politics. My friends, we have no influence and we have no power, because if we did the Governor would listen to us when we ask for the things which he knows to be for the good of the people he has sworn to serve.

We have received a direct slap in the face. What are we going to do about it? Are we going to smile and turn the other cheek or are we going to be men who have a right to be consulted on matters such as this, and men who resent being ignored absolutely when we make recommendations for the good of the health of our great state?

It has been my opinion and is my opinion now that we must become politically minded. Politicians believe in helping those who help them. We have a potential power second to none in this state. We have but to exercise that power. Will we do it or will we continue to beg for the crumbs from the master's table?

Homer Pearson, M.D.,
President,
Florida Medical Association, Inc.

A PLAN TO EVALUATE INDEPENDENTLY SEROLOGIC PROCEDURE FOR THE DIAGNOSIS OF SYPHILIS IN THE UNITED STATES.

Since the serologic conferences at Copenhagen and Montevideo, there has been an increased interest in the relative value of serologic tests for the diagnosis of syphilis. At these conferences the test of only one serologist of the United States was presented for consideration. There are a number of excellent serologists in this country, many of whom have described original modifications of the complement-fixation and precipitation tests for syphilis. It is felt that the tests of these workers merit consideration.

The United States Public Health Service is cooperating with the American Society of Clinical Pathologists in the drafting of a plan to evaluate independently serologic procedure for the diagnosis of syphilis in this country. Briefly, the plan contemplates the collection of specimens of blood from at least 1,000 individuals and the distribution of comparable specimens to the laboratories of serologists who have described an original modification of a complement-fixation or precipitation test for the diagnosis of syphilis. The donors of the specimens will be carefully selected so as to measure both the specificity and sensitivity of the serologic procedure. The sending of specimens to workers at considerable distance from the point of collection will be expedited by the use of the most modern transportation facilities, while the delivery of specimens to nearby serologists will be delayed so as to make the delivery time approximate that for those workers at the more remote points.

A committee of five members consisting of two specialists in the field of clinical syphilology, two members of the American Society of Clinical Pathologists, and one officer of the United States Public Health Service will organize the plan of study and, after all laboratory reports have been submitted by participating serologists, will interpret the results on the basis of clinical findings. The collection of the specimens will begin about December 1, 1934, and a number of serologists will be invited to take part in the evaluation scheme.

It is possible that the name of some serologist who has described an original modification of a test for syphilis may have been inadvertently omitted. Any serologist desiring to participate will be extended an invitation upon presentation

of suitable proof as to the originality of his modification of a serologic test. A brief description of the plan will also be sent to those workers who may be interested.

Correspondence should be addressed to the Surgeon General, United States Public Health Service, Washington, D. C.

RADIO BROADCAST, 1933-34

The following broadcast was arranged by the Public Relations Committee of the Florida Medical Association and given over station WRUF, Gainesville:

THE MECHANICS OF RESPIRATION*

T. H. Bates, M.D.,
Lake City.

The maintenance of animal life necessitates the continual absorption of oxygen and the excretion of carbonic acid or carbon dioxide; the blood being in all animals which possess a well-developed vascular system, the medium by which these gases are carried. By the blood, oxygen is absorbed from without and conveyed to all parts of the body, and by the blood, carbonic acid, which comes from within and represents the waste product of metabolism, is carried to those parts by which it may escape from the body. The two processes, absorption of oxygen and the excretion of carbonic acid, are complementary, and their sum is termed the Process of Respiration. In all vertebrate animals certain parts, namely the lungs, are especially constructed for bringing the blood into proximity with the aerating medium, the atmospheric air. In some of the lower animals the skin is also important as a respiratory organ and is capable of supplementing to some extent the functions of the proper breathing apparatus, but in all the higher animals, including man, the respiratory capacity of the skin is so small that it may be practically disregarded.

Essentially a lung is constructed of a fine transparent membrane, one surface of which is exposed to the air, while on the other is a network of blood vessels; the only separation between the blood and the aerating medium being the thin walls of the blood vessels and the fine membrane on one side of which the vessels are distributed. The various complexity of the respiratory membrane and the kind of aerating medium are not, however, the only conditions which cause a difference in the respiration of different animals. The number and size of the red blood corpuscles, the mechanism of the breathing apparatus, the presence or absence of the pulmonary heart physiologically distinct from a systemic, are, all of them, conditions scarcely second in their importance. It may be well to state that the lungs are only the medium for the exchange, on the part of the blood, of carbonic acid for oxygen. They are not the seat in any special manner of those combustion processes of which carbonic acid is the final result. These processes occur in all parts of the body in the substance of the tissues. The object of respiration being the interchange of gases in the lungs, it is necessary that the atmospheric air shall pass into them, and that the changed air should be expelled from them. The lungs are contained in the chest or thorax, which is a closed cavity having no communication with the outside except by means of the respiratory passages. Air enters these passages through the nostrils or through the mouth, whence it passes through the larynx into the trachea or windpipe which at about the middle of the chest divides into two tubes or bronchi, one of which goes to the right lung and one to the left. These bronchi continue to divide into smaller and smaller tubes in the substance of the lungs until at length they end in the smallest sub-divisions, which are called lobules. The walls of the trachea and bronchi are composed of a lining layer of epithelium supported by a framework of connective tissues, muscle fibers and rings of cartilage. As the bronchi become smaller and smaller the cartilaginous rings become scarcer and more irregular until in the smaller bronchial tubes they are represented only by minute and scattered flakes, eventually disappearing leaving the walls composed only of muscle fibers and connective tissue covered only by a thin mucous membrane.

The terminal subdivisions of the bronchi just mentioned are the minute parts that are called air cells or alveoli, and it is in these that the air and blood are brought into intimate contact. The structure of the lungs is more or less spongy and elastic so that on cross section the appearance is that of a solid tissue except for here and there where the larger bronchi have been cut across and show on the surface of the section their tubular structure. In fact, however, the lungs are hollow organs, each of which communicates

*Radio Braodcast delivered under auspices of Florida Medical Association over Station WRUF, Gainesville, December 24, 1933.

by a separate orifice with a common air tube—the trachea. The lungs occupy the greater portion of the thorax and are in intimate contact with the chest wall. Their surface is covered by a serous membrane, the pluera, one layer of which also covers the inner surface of the chest wall. This serous covering of the lung and chest wall provides a smooth, slippery covering which allows the free movement of the lungs within the chest cavity. Throughout the pluera covering the lungs there are elastic fibers supported by connective tissue and scattered bundles of muscle fibers. Each lung is divided into subdivisions called lobes and each lobe is again subdivided into smaller parts called lobules. Each lobule may be considered to be a lung in miniature, consisting as it does of a branch of the bronchial tube, air cells, blood vessels, nerves and lymphatics, all supported by connective tissue and a sparing amount of areolar tissue. As has just been said the lobule consist of a group of air cells arranged about the terminal bronchial tube in such a way as to permit the free passage of the air into them. The walls of the air cells contain elastic tissue fibers which add to the strength of the air cell walls and at the same time provide power for the recoil after the distention of the cell during the process of breathing.

In between these elastic fibers run the small blood vessels carrying the blood which will be aerated during the respiration. Also there are blood vessels that carry nutrient blood to the tissues of the lungs. The nerves of the lungs which arise largely from the sympathetic system follow the course of the vessels and bronchi.

The acts of respiration consist of the alternate expansion and contraction of the thorax by means of which air is drawn into or expelled from the lungs. For inspiration of air into the lungs it is evident that all that is necessary is such a movement of the side walls or floor of the chest or both, that the capacity of the interior shall be enlarged. By such increase of capacity there will, of course, be a diminution of the pressure of the air in the lungs and a fresh quantity will enter through the larynx and trachea to equalize the pressure on the outside and inside of the chest. For the expiration of air, on the other hand, it is also evident that by an opposite movement which shall diminish the capacity of the chest, the pressure of the interior shall be increased and the air will be expelled until the pressure within and without are again equal. In both cases the air passes through the trachea and larynx whether entering or leaving the lungs, there being no other communication with the exterior of the body, and the lung for the same reasons under all circumstances described is closely in contact with the walls and floor of the chest. To speak of the expansion of the chest, therefore, is to speak also of the expansion of the lungs.

The enlargement of the chest in inspiration, is a muscular act, the effect of the action of the inspiratory muscles being an increase in the size of the chest cavity in the vertical and in the lateral and antero-posterior diameters.

The muscles engaged in ordinary inspiration are the diaphragm which forms the floor of the chest and the muscles of the chest walls. The vertical diameter of the chest is increased by the action of the diaphragm, which by contracting pulls the floor of the chest downward. The lateral and antero-posterior diameter is effected by the raising of the ribs which is brought about by the action of the muscles on the external surface of the chest wall, and by the layers of muscle between the ribs. The expansion of the chest in inspiration presents some peculiarities in different persons. In young children chiefly by the diaphragm which being highly arched in expiration becomes flatter as it contracts and descending presses on the abdominal viscera and pushes forward the front walls of the abdomen. The movement of the abdominal walls being here more manifest than that of any other part, it is usual to call this the abdominal type of respiration. In adults, together with the descent of the diaphragm and the pushing forward of the front wall of the abdomen, the chest and sternum are subject to a wide movement in inspiration giving rise to the name costal type of respiration.

From the enlargement produced in inspiration the chest and lungs return in ordinary tranquil expiration by their elasticity; the force employed by the inspiratory muscles in distending the chest and overcoming the elastic resistance of the lungs and chest walls, being returned as an expiratory effort when the muscles are relaxed. This elastic recoil of the chest and lungs is sufficient in ordinary quiet breathing to expel the air from the lungs in the intervals of inspiration, and no muscular power is required. In all voluntary expiratory effort, however, as in speaking, singing, blowing and the like, and in many involun-

tary actions such as sneezing, coughing, etc., something more than merely passive elastic power is necessary, and the proper expiratory muscles are brought into action. The chief of these are the abdominal muscles which by pressing on the viscera of the abdomen push up the floor of the chest formed by the diaphragm and by thus making pressure on the lungs expels air from them. All muscles, however, which depress the ribs act also as muscles of expiration. When by the efforts of the expiratory muscles the chest has been squeezed to less than its average diameter it again on relaxation of the muscles returns to its normal dimension by virtue of its elasticity. The construction of the chest walls admirably adapts them for recoiling against and resisting as well undue contraction as undue dilatation. Under ordinary circumstances the degree of contraction or dilatation of the lungs is dependent on that of the boundary walls of the chest. Having discussed the means by which respiration is carried on, that is, air drawn into and expelled from the lungs, one might consider the changes that take place in the air so breathed. The atmosphere we breathe consists of a nearly uniform mixture of oxygen, nitrogen, carbon dioxid and watery vapor with traces of other gases. Of every one hundred volumes of pure atmospheric air seventy-nine volumes consist of nitrogen and the remaining twenty-one of oxygen. The proportion of carbon dioxid is extremely small, averaging only four or five parts to each ten thousand volumes. The quantity of watery vapor varies greatly according to temperature and other circumstances, averaging about 1.4 per cent. The changes effected by respiration in the atmospheric air are an increase in temperature, an increase in the quantity of carbon dioxid, a diminution of volume, an increase in the amount of watery vapor and the addition of minute amounts of organic matter and free ammonia. These changes take place by virtue of the air coming in contact with the warm surface of the lungs and by the interchange of gases. The carbon dioxid is increased by the giving up of this gas by the blood as it passes through the small vessels in the walls of the air cells. At the same time the oxygen of the inspired air is being absorbed by the blood. The volume of the air is diminished due to a portion of the oxygen being absorbed and not returned in the excreted carbon dioxid. The amount of oxygen absorbed is on an average about five per cent so that the expired air contains only sixteen volumes per cent of that gas. The watery vapor is increased generally to a sufficient point that the expired air is saturated, or very nearly so. This amount will, of course, be influenced by various factors. A small quantity of ammonia and organic matter is added to the ordinary constituents of expired air and is derived at least in part from decomposing particles of food left in the mouth or from carious teeth or the like, and is therefore only an accidental constituent of expired air. The changes that take place in the blood consist chiefly in giving up of carbon dioxid and the absorption of oxygen, the whole depending upon the chemical combining of the oxygen with the hemoglobin of the blood. A discussion of this process would necessitate a longer period of time than is now available. Suffice it to say briefly that the mechanics of respiration consist of the drawing into the chest of atmospheric air, a diffusion of gases and a chemical combination of oxygen with blood resulting in the maintenance of animal life.

STATE NEWS ITEMS

Dr. Julius C. Davis of Quincy, chairman of the Committee on Legislation and Public Policy, was a visitor in Jacksonville recently, conferring with Dr. Driskell, who is also a member of the Committee, and Dr. Shaler Richardson, secretary of the Association. Dr. Davis is very anxious to hear from all members of the State Association relative to any medical legislation that is to be taken up at the next session of the Legislature. The Legislative Committee would like to have all such information at an early date in order that bills may be properly drawn up and introduced at the very beginning of the Legislature. Also, it is important that the members of the Association be informed regarding all medical legislation so that they may contact their representatives.

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Dr. V. M. Johnson has returned to West Palm Beach after spending several weeks at the Mayo Clinic where he reviewed certain phases in the field of surgical pathology.

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Dr. J. Ralston Wells of Daytona Beach attended the meeting of the Chattahoochee Valley Medical and Surgical Association at Radium Springs, July 10 and 11. He read a paper on "Pre- and Post-Operative Management of Surgical Patients with Mention of Choice of Anesthetic."

Dr. M. J. Myres of Daytona Beach spent some time in Jacksonville the early part of August.

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Dr. and Mrs. H. A. Barge of Miami have returned from a trip to Newnan, Ga., Atlanta, Nashville, Memphis, Hot Springs, New Orleans and Birmingham. Dr. Barge attended clinics at Vanderbilt and visited the U. S. Leprosy Hospital at Carville, La.

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Dr. and Mrs. W. W. Massey of Quincy have returned from a two weeks' visit in the mountains of North Carolina.

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Dr. Leland H. Dame and family of Inverness spent their vacation in Georgia, South Carolina and on the east coast during the month of July.

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Dr. and Mrs. A. J. Floyd of Palmetto announce the birth of a daughter, Mary Margretta, on June 24.

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Dr. and Mrs. Thomas C. Kenaston of Cocoa spent the month of August in New York City, where Dr. Kenaston took post-graduate work.

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Dr. Nelson M. Black and son, Nelson, Jr., of Miami, and Dr. and Mrs. Cayetano Panettiere of Miami Beach recently spent a delightful vacation motoring through the west. While on this trip they spent some time at Grand Canyon, Arizona.

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Dr. V. A. Hughes of Jacksonville announces the opening of his office at 302 St. James Building.

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Dr. R. C. Woodard of Miami has returned from a vacation spent at Mt. Eagle, Tenn.

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Dr. George L. Cook of Tampa recently spent a vacation in Virginia and Georgia.

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Among Miami doctors who included the World's Fair in their vacation plans were: Drs. M. C. Wilson, L. S. Rentz, E. Sterling Nichol and Kenneth Phillips.

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Dr. and Mrs. B. F. Woolsey of Jacksonville have returned from Chicago where they spent ten days visiting the World's Fair and friends.

The following members of the Association attended the Southern Pediatric Seminar which was held at Saluda, N. C., from July 26 to August 4:

Besenbruch, P. W., Davenport.
Black, R. C., Plant City.
Box, C. C., Graceville.
Chowning, W. C., New Smyrna.
Denton, J. T., Sanford.
Kennon, C. L., Miami.
Massey, William C., Quincy.
Mitchell, W. E., Coleman.
Pay, W. C., DeLand.
Tomlinson, J. P., Lake Wales.
Walkup, A. C., St. Augustine.
Wilkinson, B. A., Tallahassee.

* * *

Dr. Joseph H. Lucinian and family of Miami have gone north for a month's vacation. Dr. Lucinian will spend some time in the x-ray clinics of Baltimore, Philadelphia and Boston. He will attend the meeting of the American Roentgen-Ray Society which is to be held in Pittsburgh the latter part of September.

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Dr. M. D. Thomas and family, who have spent the summer at Old Orchard, Me., have returned to Miami Beach, where Dr. Thomas has reopened offices at 211 Sixth Street.

* * *

Dr. M. C. Wilensky of the State Hospital at Chattahoochee has returned from Denver where he attended post-graduate courses in ophthalmology and otolaryngology.

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Dr. J. B. Parramore of Jacksonville recently returned from an extensive trip north. He spent four months at the Mayo Clinic at Rochester, Minn., then visited the Fair in Chicago. He also spent two weeks in the mountains of North Carolina before his return home.

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Dr. T. O. Otto of Miami is vacationing in Massachusetts, Maine and Canada. He plans to return about October 20th.

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Dr. R. M. Harris of Miami has returned from an extended trip to North Carolina, Baltimore, and New York.

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Dr. S. Ward Fleming of West Palm Beach recently spent several weeks in eastern surgical clinics.

A meeting of the East Coast Medical Association will be held in Orlando, October 19th and 20th, according to an announcement by President Leigh F. Robinson. While membership in the East Coast Medical Association includes members of the Florida Medical Association who practice in the counties along the east coast, all members of the Florida Medical Association are welcome to attend.

Dr. Spencer A. Folsom of Orlando is the secretary and advises that the program will be completed and mailed out as early as possible. One interesting feature of the program will be a symposium on Backache. The banquet and dance will be held the night of October 19th. The main program will open at noon, October 19th, and close at noon on the 20th. Dr. Folsom is working hard to complete the details of the program and different phases of the entertainment through local committees.

Every member from Fernandina to Key West on the east coast is urged to attend and all members in other parts of the State who can conveniently attend this meeting will not be disappointed. Please put "October 19th and 20th, Orlando" on your calendar and make arrangements to attend the meeting. When the Orlando doctors act as hosts, a good meeting and fine entertainment are always assured.

* * *

The American College of Physicians will hold its Nineteenth Annual Clinical Session in Philadelphia, April 29- May 3, 1935.

Announcement of these dates is made particularly with a view not only of apprising physicians generally of the meeting, but also to prevent conflicting dates with other societies that are now arranging their 1935 meetings.

Dr. Jonathan C. Meakins, of Montreal, Que., is President of the American College of Physicians, and will arrange the Program of General Sessions. Dr. Alfred Stengel, Vice President in Charge of Medical Affairs of the University of Pennsylvania, has been appointed General Chairman of local arrangements, and will be in charge of the Program of Clinics. Mr. E. R. Loveland, Executive Secretary, 133-135 S. 36th Street, Philadelphia, Pa., is in charge of general and business arrangements, and may be addressed concerning any feature of the forthcoming Session.

HARRY LYMAN PUTNAM

Dr. Harry Lyman Putnam, one of St. Petersburg's leading physicians, died at the Mission Hospital in Asheville, N. C., on July 27, 1934, following a short illness due to an acute dysentery. Dr. Putnam was born Sept. 9, 1863, at Houlton, Maine. In 1890 he was graduated from the Bellevue Medical College following which he returned to Houlton where he practiced medicine until 1919 when he moved to St. Petersburg where he lived and practiced until the time of his death.

He had served as President of the Pinellas County Medical Society, was a member of the staff of the Mound Park Hospital, he was examiner for his local examining board during the World War, and for a number of years had been United States Pension Examiner. He was one of the founders of the United Liberal Church in St. Petersburg and for two terms served as president of the official board of that church. Dr. Putnam was a member of the Pinellas County Medical Society, the Florida Medical Association and the American Medical Association.

He is survived by his widow, Mrs. H. L. Putnam and one son, Donald E. Putnam.

The following resolution was passed by the Pinellas County Medical Society.

"*Whereas*, God in His infinite wisdom hath seen fit to remove from our midst one of our most beloved brothers, Dr. Harry Lyman Putnam, and

"*Whereas*, by his untiring devotion to the practice of medicine and his sacrifices in the interest of charity, he endeared himself to the entire community, and

"*Whereas*, we, the members of the Pinellas County Medical Society, feel deeply the loss of our beloved brother and friend: therefore, be it

"Resolved, that the Pinellas County Medical Society express its sorrow in the passing of Dr. Harry Lyman Putnam; that a copy of this resolution be sent to his wife; that a copy be entered on the minutes of this society; and that the same be published in the Journal of the Florida Medical Association."

WANTED: Used medical office furniture and equipment. Write P. H. G., care Florida Medical Journal, Box 81, Jacksonville.

COMPONENT COUNTY SOCIETIES

BAY COUNTY MEDICAL SOCIETY

At a meeting of the Bay County Medical Society, held August 16th at Panama City, the following program was presented:

"Common Ear Conditions", M. A. Lischkoff, Pensacola.

Discussions: F. E. McClane, Panama City; W. P. Roberts, Dothan, Ala.; J. H. Fellows, Pensacola.

"Symposium on Cancer Control", James H. Hoffman, Pensacola.

Discussions: W. C. Payne, Pensacola; John T. Ellis, Dothan, Ala.

"Hematuria—With Lantern Slides", John T. Ellis, Dothan, Ala.

Discussion: W. C. Payne, Pensacola.

"Location of Hemorrhage in Brain Due to Birth Injuries", J. H. Fellows, Pensacola.

"Miscellaneous Discussion", A. E. Conter, Apalachicola.

A meeting of the Bay County Medical Society was held on August 23 at which Dr. James S. McLester of Birmingham, president-elect of the American Medical Association, was guest of honor. At this meeting, which was an informal one, many topics of general interest were discussed.

DADE COUNTY MEDICAL SOCIETY

At the meeting of the Dade County Medical Society held September 7, the following program was given:

"Trichomonis Vaginalis", Robert T. Spicer.

"The Rectum, a Frequently Neglected Field", E. Donald.

MARION COUNTY MEDICAL SOCIETY

THE MARION COUNTY MEDICAL SOCIETY BECOMES THE NINETEENTH COMPONENT SOCIETY TO SEND IN 100% OF DUES FOR 1934. THIS SOCIETY HAS INCREASED ITS MEMBERSHIP 50% OVER LAST YEAR BY REINSTATING DOCTORS WHO HAVE DROPPED OUT DURING PAST YEARS AND BY ADDING NEW NAMES TO ITS ROSTER.

WOMAN'S AUXILIARY

TO THE

FLORIDA MEDICAL ASSOCIATION, INC.

State Editor

MRS. S. M. COPELAND

1356 Willowbranch Ave.,

Jacksonville, Florida

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The following recommendations made by the Woman's Auxiliary at the A. M. A. Convention in Cleveland, Ohio, June 11-16, 1934, are hereby published for the benefit of those who were not able to attend the convention and for those who do not subscribe to the American Medical Journal.

RECOMMENDATIONS OF PRESIDENT, Mrs. James F. Blake.

1. *Whereas*, the American Medical Association has entered into cooperative relationships with other organizations interested in the public health, to-wit, the General Federation of Women's Clubs, the National Congress of Parents and Teachers, the National Committee for Boys' and Girl's Club Work and the National Educational Association; and

Whereas, these relations have led to cooperative plans and policies in furtherance of the public health; and

Whereas, these relationships may be expected to undergo development or modification from time to time.

THEREFORE, BE IT RESOLVED, by the Woman's Auxiliary to the American Medical Association, that the Auxiliary officers, local, state and national, familiarize themselves with the cooperative relationships aforementioned, and that any proposed plans for cooperative work with other associations be undertaken only with the advice of the component county medical societies, the constituent state medical societies, or the American Medical Association.

2. *Whereas*, during the past year circular letters have been sent out by a State President relating the particular activities of this State President and the work of one or more counties in this state, which said circularizing of states is against the

procedure of the Auxiliary to the American Medical Association.

Be It Resolved to reiterate our stand that no letters of a circularizing nature are allowed unless the President of the Auxiliary to the American Medical Association has given her consent after she in turn has taken up the subject material with the Advisory Board if necessary, or the National Committee Chairman directly interested.

Also, be it brought to the attention of every State Chairman of a department of work that all program work must be submitted to her State Advisory Council, and the National Chairman corresponding to her work in the individual state, for approval. No Chairman to circularize any state outside of her own, unless under conditions aforementioned.

Recommendations of Treasurer,
Mrs. James F. Percy.

1. That a substantial sum be allotted to the Corinne Keen Freeman Memorial Fund each year at the National Convention as a part of the duties of the voting body until it reaches a sum of four thousand dollars.

2. That for this year a sum of five hundred dollars be ordered transferred to the Corinne Keen Freeman Fund.*

3. That this fund shall be known as the Corinne Keen Freeman Resolving Fund and its purpose for the use of incoming Presidents.

Recommendations of the Finance Committee,
Mrs. Fred L. Adair, Chairman.

We recommend that the budget be based upon our actual income alone, which at the present time is from National dues, and that additional dues may be drawn upon by the President for the discretionary account.

Recommendation of Treasurer, Finance and Supplies Chairman.

That the Chairman of printing have the ordering and distribution of the Treasurer's supplies, Handbooks, Filing Cards, and any other supplies that may properly come to this department for distribution and further, that provision be made for this work in the preparation of the budget.

Recommendations of Legislative Chairman
Mrs. Philip Schuyler Doane.
(Favorably referred to Revisions Committee)

Recommended, that this organization shall be known as The American Medical Auxiliary.

*Amended amount from $800.00.

Recommendations of Program Chairman,
Mrs. Arthur B. McGlothlan.

1. That we reprint 2000 (or 3000) copies of Study Envelope No. 3, which is now out of print.

2. That we revise, if need be, and reprint 2000 (or 3000) copies of Study Envelope No. 2, which is the most popular of our studies and of which there are on hand 735 copies.

3. That if possible sufficient money be allowed to reprint near the end of this year Nos. 4 and 5 if the demand for them continues and indicates that we shall need more at that time.

4. That part of the studies be printed without envelopes since some organizations prefer them without envelopes.

5. That we permit other organizations which distribute our studies among their members to use a stamp saying "distributed by (name of organization)".

6. When articles appear in Hygeia which are desired for use in our educational work, if such articles can be furnished to us by the A. M. A. at a price which is less than that for which we can print such articles, that we purchase such materials from the A. M. A. instead of having them printed elsewhere.

7. Some requests have come to us to allow other organizations to reprint our studies. I recommend that we permit other organizations to reprint our literatue, provided the auxiliary is given the credit for the literature, and provided that such duplication of literature be subjected to review by the Program Committee before being printed by another organization and provided, that this recommendation first be approved by the Woman's Auxiliary Advisory Council.

Recommendations of Public Relations Committee,
Mrs. David S. Long.

1. That the auxiliary support, through individual members in various communities, the policy of the National Congress of Parents and Teachers to encourage Summer Roundup Examination in office of family physician in preference to organized clinics. The latter to be supported only when the former is impracticable and then in cooperation with the Medical Society.

2. That the County Chairmen of Public Relations when authorized by the County Medical Society select material from the Hygeia new sheets for local publicity.

3. That Regional or County Health Institutes be promoted and to be dignified with a printed or typed program.

Recommendations of Historian,
Mrs. Willard Bartlett.

1. That the Guide for Historians issued this year to assist in preparing state and county histories be included in the next printing of the Handbook.

2. That as *The First Twelve Years* has been issued in answer to an express desire for information and also as a stimulus for the work of the auxiliary, that the Program Committee recommend its inclusion in county programs during the coming year.

3. That to assist its distribution and sale the Executive Board recommend to State and County Presidents or their representatives at this meeting that they order at ten cents a copy a substantial number for sale or distribution to their members.

4. That the Historian be allowed a budget sufficient to communicate at least twice a year with all State Historians for follow-up work where needed, and to assure the yearly addition to the National, State, and County records.

5. That Historians and Chairmen of Archives who have done able work be not changed oftener than necessary.

6. That a list of specific tasks supplementing the National Program to be accomplished by the County Auxiliaries be issued at the beginning of the coming year as has on occasions previously been done.

Recommendations of Press and Publicity Committee,
Mrs. Robert E. Fitzgerald.

1. It is again recommended to the attention of the auxiliary women that the *Bulletin of the American Medical Association* is available to the wives of all Fellows of the American Medical Association. Those members of the American Medical Association who are not Fellows have the opportunity of subscribing to the *Bulletin* at a cost of fifty cents a year. It then follows that the auxiliary section of the *Bulletin* is available to practically all auxiliary women. It is recommended that members make it a point to read this periodical and that county presidents take steps to call the attention of all county members to the *Bulletin*.

2. It is recommended that there be a quarterly *News Letter* sent to the president, president-elect, and chairman of press and publicity of each state.



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ADVERTISERS' NOTES



The new Lilly Research Laboratories are nearing completion and will be ready for occupancy in early October.

Throughout an existence of nearly sixty years Eli Lilly and Company have been guided in their efforts to serve the professions by men whose primary interest has been the production of medicinal products for use in prescriptions written by physicians. Colonel Eli Lilly, the founder, was a skilled pharmacist with an aptitude and enthusiasm for his work, for making prescription supplies in new and better ways. His son, Josiah K. Lilly, throughout his connection with the company, a period covering fifty-eight years, has been a persistent experimenter who has constantly sought to improve products and processes. To him belongs the credit for establishing the first Lilly research activities in a special laboratory devoted wholly to that phase of the industry.

A member of the third generation of the Lilly family, Eli Lilly, grandson of the founder, is now president of the organization and it is under his direction that the culminating point in Lilly research activities has been attained through the completion of the magnificent structure that will be formally opened in the fall. These new laboratories will embrace the very latest facilities for scientific work and they will also reflect the progress of modern medicine. A broad and far-reaching program has been planned in keeping with the spirit of medical research and the aspirations of a company that since its inception has recognized the need for close affiliation of research with practice.

The Merck Manual

The sixth edition of the manual was officially presented to the medical profession at the meeting of the American Medical Association held at Cleveland during the week of June 11.

Therapy in the new manual has been outlined by Dr. Bernard Fantus, Professor of Therapeutics, College of Medicine, at the University of Illinois, and has been approached, not only as a

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From an original two hundred and fifty pages in 1899, the Merck Manual has grown to one thousand, three hundred and seventy-nine pages in the present edition. The new edition, the sixth since the founding of the publication, has been entirely rewritten yet maintains the characteristics of preceding editions, which have made it the standard reference manual for the majority of physicians, students, pharmacists and nurses.

The sixth edition of the Merck Manual is printed on fine paper and bound in dark blue fabrikoid covers with gold stamping. It is available only to members of the medical profession, pharmacists, chemists and those in allied professions, at the nominal price of two dollars per copy, representing the actual cost of printing and distribution.

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THE CLINICAL STATUS OF VITAMIN D MILKS

Despite its recent exploitation, vitamin D milk is not a new product, but in some form has been available to physicians in this country for about seven years. In 1927, after extensive research by Dr. G. C. Supplee and clinical tests by the late Dr. Alfred F. Hess, the well-known powdered milk, Dryco, was irradiated under the Steenbock patent and offered to physicians as a prescription product of value in the control of infantile rickets.

In the summer of 1931, following comprehensive clinical investigations by Dr. A. F. Hess, the Walker-Gordon Laboratories announced the production of a new vitamin D certified milk, made potent in the antirachitic vitamin by scientific feeding of irradiated yeast to the cows.

As the result of still further laboratory and clinical research, The Borden Farm Products Company of Michigan placed on the market in January, 1933, an irradiated pasteurized fluid milk, the vitamin D content of which had been enriched by subjecting the milk in a thin film to the ultraviolet rays from a carbon arc lamp.

A third method for the production of vitamin D milk has also been devised. This consists of the modification of milk with a vitamin D concentrate of cod liver oil, according to the process patented by Zucker.

Numerous clinical experiences and laboratory investigations on vitamin D milk, some 50 of which have been reviewed in The Borden Digest since 1931, have clearly demonstrated that irradiated milk is the most practical and efficacious antirachitic now available to physicians, although natural vitamin D milk from cows fed on irradiated yeast is also a reliable and potent antirachitic. Milk fortified with a concentrate of vitamin D is apparently the least effective.

One explanation of the excellent results achieved with irradiated vitamin D fluid milk lies in the fact that milk contains the provitamin, cholesterol, in its fat and also in its protein, and this important substance is activated by irradiation to form vitamin D. Milk is likewise the best dietary source of calcium and phosphorus, minerals which are as essential to the prevention and cure of rickets as is vitamin D. Milk is, furthermore, an excellent source of vitamin A, which some authorities believe may be a factor in the control of rickets (see Abstract No. 2041 above).

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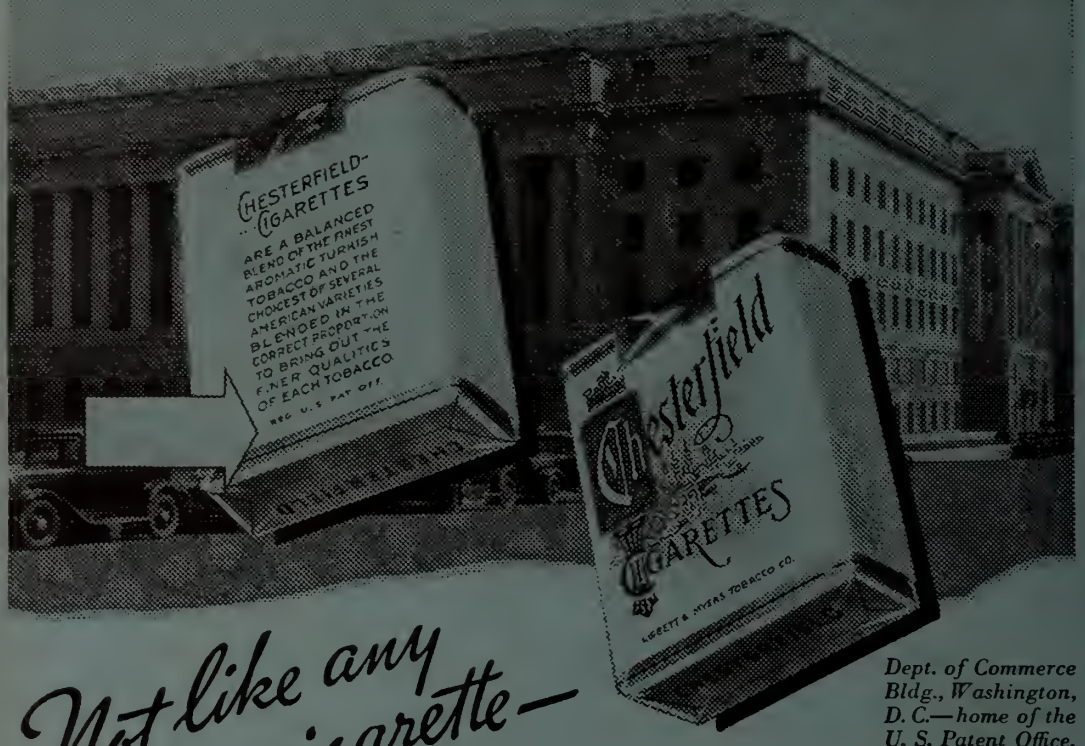
SCHEDULE OF MEETINGS—COMPONENT SOCIETIES FLORIDA MEDICAL ASSOCIATION

COUNTY SOCIETY	SECRETARY	MEETINGS				Dues Paid.
		Date	Time	Place	Luncheon?	
Alachua	Harry M. Merchant, M.D., Gainesville.	2nd Tuesday	12:00 Noon	White House Gainesville	Yes.	90%
Bay	Allen H. Miller, M.D., Millville.					71%
Brevard	I. K. Hicks, M.D., Melbourne.	2nd Tuesday		Varies	Yes.	67%
Broward	O. C. Brown, M.D., Ft. Lauderdale.	Last Wednesday.	8:00 P.M.	Elks' Hall Ft. Lauderdale	No.	94%
Columbia	T. H. Bates, M.D., Lake City.	1st Monday	7:30 P.M.	Blanche Hotel Lake City		100%
Dade	Robert T. Spicer, M.D., Miami.	1st Friday	8:30 P.M.	Club Room Huntington Bldg. Miami	Occasionally.	95%
DeSoto-Hardee-Highlands	L. W. Martin, M.D., Sebring.	2nd Tuesday	8:00 P.M.	Varies	Yes.	93%
Duval	B. F. Woolsey, M.D., Jacksonville.	1st Tuesday	8:15 P.M.	Mayflower Hotel Jacksonville	No.	83%
Escambia	J. M. Hoffman, M.D., Pensacola.	2nd Tuesday	8:00 P.M.	Board of Health Building Pensacola	No.	71%
Hillsboro	John S. Helms, Jr., M.D., Tampa.	1st Tuesday	8:00 P.M.	Tampa Municipal Hospital Tampa	No.	100%
Jackson	Lewis Pierce, M.D., Marianna.	2nd Tuesday	7:30 P.M.	Hotel Chipola, Marianna	Yes.	91%
Lake	W. L. Ashton, M.D., Umatilla.	1st Thursday	12:30 P.M.	Eustis	Yes.	94%
Lee	Robley D. Newton, M.D., Ft. Myers.	3rd Friday	7:30 P.M.	Lee Memorial Hospital Ft. Myers	No.	100%
Leon-Gadsden-Liberty-Wakulla-Jefferson	O. G. Kendrick, M.D., Tallahassee.	Quarterly	3:00 P.M.	Varies	Yes.	100%
Madison	Geo. O. Davis, M.D., Madison.					100%
Manatee	W. D. Sugg, M.D., Bradenton.	3rd Tuesday	7:00 P.M.	Whitfield Country Club Bradenton	Yes.	100%
Marion	Richard C. Cumming, M.D., Ocala.	3rd Thursday	12:30 P.M.	Marion Hotel Ocala	Yes.	100%
Monroe	W. R. Warren, M.D., Key West.	1st Sunday	9:00 P.M.	Varies	Yes.	100%
Orange	John A. Pines, M.D., Orlando.	3rd Wednesday	8:30 P.M.	Varies	No.	100%
Palm Beach	R. Henry Baldwin, M.D., W. Palm Beach.	4th Monday	8:00 P.M.	Good Samaritan Hospital W. Palm Beach	No.	100%
Pasco-Hernando-Citrus	Geo. R. Creekmore, M.D., Brooksville.	2nd Thursday	7:00 P.M.	Varies	Yes.	100%
Pinellas	O. O. Feaster, M.D., St. Petersburg	1st Friday	8:00 P.M.	Assembly Room, 5th floor, P. & L. Bldg St. Petersburg	No.	100%
Polk	J. R. Boulware, Jr., M.D., Lakeland.	2nd Wednesday in Feb., Apr., June, Aug., Oct., Dec.	1:00 P.M.	Lakeland	Yes.	98%
Putnam	E. W. Warren, M.D., Palatka.	2nd Thursday	7:00 P.M.	James Hotel, Palatka	Yes.	100%
St. Johns	Reddin Britt, M.D., St. Augustine.	3rd Tuesday	8:30 P.M.	Varies	Yes.	100%
St. Lucie-Okeechobee-Indian River-Martin	J. D. Parker, M.D., Stuart.	3rd Thursday	8:00 P.M.	Varies	Yes.	92%
Sarasota	J. E. Harris, M.D., Sarasota.	2nd Tuesday	8:30 P.M.	Varies	Occasionally.	100%
Seminole	J. T. Denton, M.D., Sanford.	2nd Monday	7:00 P.M.	City Hospital Sanford	Yes.	100%
Sumter	W. E. Mitchell, M.D., Coleman.	2nd Tuesday		Varies	No.	100%
Taylor	C. A. O'Quinn, M.D., Perry.	Last Friday	8:00 P.M.	Dixie-Taylor Hotel Perry	Yes.	100%
Volusia	Joseph H. Rutter, M.D., Daytona Beach.	2nd Tuesday	7:30 P.M.	Varies	Yes.	94%
Walton-Okaloosa	A. G. Williams, M.D., Lakewood.	3rd Thursday	8:00 P.M.	Varies	Occasionally.	100%

NOTE—Secretaries: Please submit information to complete the above schedule.

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NO. 4

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NEXT SESSIONS Florida Medical Association, Ocala, May 13, 14, 15, 1935.
Southern Medical Association, San Antonio, November 13-16, 1934.
American Medical Association, Atlantic City, June 10-14, 1935.

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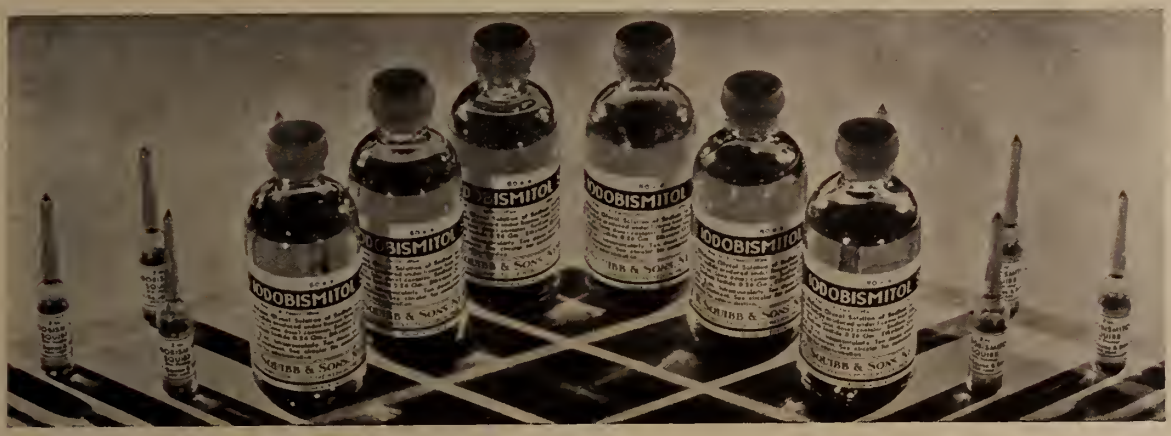
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THE ROENTGENOLOGIST AS A CONSULTANT IN ACUTE ABDOMINAL CONDITIONS*

O. O. Feaster, M.D.,
St. Petersburg.

Roentgenology is one of the youngest of the medical specialties. Less than two score years have passed since Roentgen discovered the "ray." Years of patient study and careful observation by numerous workers have been necessary for the establishment of a foundation upon which to build. Improvements in equipment and development of technic were essential to advanced accomplishments. The x-ray machine during these formative periods was just another piece of equipment in the office of the general practitioner, the surgeon or the internist—its use limited to the examination of a bone, a lung or, on occasion, a stomach. Gradually there developed among these practitioners individuals who demonstrated a desire for and a special proficiency in this type of diagnostic practice. The x-ray specialist was born—a man of special training in the interpretation of screen and film shadows based upon a knowledge of physiology and pathology obtained from experience in the practice of general medicine, a knowledge kept alive and fresh from constant contact with almost every field of medical practice in his daily work, so wide are the ramifications and usages of x-ray practice today.

The roentgenologist, to give that help of which he is capable, that help to which the attending physician and the patient are rightfully entitled, must be looked upon as a medical consultant. If he confines his diagnostic opinions to reading from films or the screen, without taking into consideration the history, physical signs and symptoms of the disease process under study, and interpreting his findings in the light of these, he is failing to give the help of which he is capable. If the referring physician asks only an opinion based on the reading of a film he is restricting the usefulness of the roentgenologist; he is refusing, or failing to take advantage of, the aid which a medical consultant may give to him and, through him, to the patient.

Not infrequently one is requested to "just fluoroscope the lungs," "only make one film of the stomach," "do a single film of the ankle" and other equally absurd and ridiculous restrictions. Quite analogous would be calling these men into consultation in a heart case and demanding that they make a diagnosis of the lesion but limit their examination entirely to palpation; a lung diagnosis, by percussion only; or of an infectious disease from an inspection of the temperature chart alone. To accede to such restrictive requests is to oftentimes render one unable to help and the self-respecting roentgenologist will naturally not permit himself to be so handicapped. At times the referred patient, because of gastric pathology, will be found, instead, to have gallbladder disease, chronic appendicitis, pulmonary tuberculosis or a cardiac lesion to account for his symptoms.

We are convinced that the doctor who interprets his own films made by some technician or who uses an office fluoroscope places himself at a definite disadvantage and, except possibly in fracture work, would be a better diagnostician without this help because of the false sense of security which these means give to him. Many are the early pulmonary lesions that are missed in a fluoroscopic examination either because they are unable to be seen except on stereoscopic films of excellent quality or because the doctor did not allow sufficient time in the darkened room for proper fluoroscopic vision. How easy it is for the urologist looking for a stone in his kidney film to fail to observe an old unrecognized spine fracture, malignant metastasis, arthritis, or slight erosion from an abdominal aneurism that may be causing the pain for which the patient consulted him. And how vastly more untenable is the position of the doctor who seeks and accepts the opinion of an x-ray technician—certainly this same physician would not be willing to accept as a heart consultant a nurse because she was trained in taking blood pressure readings.

Please understand that it is not intended to convey the idea that all x-ray knowledge is con-

*Read before the Sixty-first Annual Meeting of the Florida Medical Association, Jacksonville, April 30, May 1 and 2, 1934.

fined to roentgenologist or that roentgenologists are infallible. We have seen good x-ray work in limited fields by other doctors and our own errors and failures too often for that; but it is intended to impress the fact that the roentgenologist can be of most value when his help is sought as a medical consultant and not as an x-ray technician.

Certainly no phase of the practice of medicine entails a greater responsibility than the proper handling of acute conditions within the abdomen. Often the life of the individual depends upon a proper diagnosis or at least upon the decision that a laparotomy is necessary even if a positive diagnosis cannot be made. Not infrequently the percentage of lives saved is inversely proportional to the hours of delay. Any procedure which helps to make a diagnosis more certain and helps to make it earlier should not only be welcomed by the attending physician and the surgeon who are shouldering the responsibility but may also be the means of increasing the chances for recovery of the patient by more prompt operative interference.

Material assistance in acute abdominal conditions may often be obtained from the roentgenologist. In fact, in some instances his work will determine definitely a diagnosis that will make the decision to operate immediately, or not at all, an easy one. X-ray procedures in such cases with proper equipment usually entail no harmful results to the patient. The detailed technic of the examinations will, of course, not be of interest to the majority of those present so no effort will be made to bore you with them. In general, the finding of free air under the diaphragm in a patient with sudden sharp pain and collapse in whom a perforated peptic ulcer is suspected is sufficient to prove this diagnosis; a similar spontaneous pneumoperitoneum in a patient with a gunshot wound of the belly is sufficiently definite proof of an intestinal perforation to justify this diagnosis and serve as a guide for operative interference at such time as in the surgeon's opinion it is indicated. Many a surgeon has been saved the embarrassment of doing a laparotomy for acute appendicitis by the finding of a stone in the right ureter. Among the conditions which do not necessitate such early operative interference but in which the roentgenologist may give a measure of assistance are the finding of an elevated and fixed diaphragm, with possibly free gas and a fluid level, in a sub diaphragmatic abscess and the diagnosis of diverticula may be of value.

The discovery of the transverse colon lying between the liver and the diaphragm, of a hernia of the stomach or a section of intestine through the diaphragm, of a pneumonia, of pus in the chest, of an unsuspected lung condition rendering ether anesthesia inadvisable are often of material assistance to the surgeon.

In probably no other acute abdominal condition can the roentgenologist be of greater help than in acute intestinal obstruction. From a single film, always without the administration of the barium meal, frequently with the mobile or portable x-ray machine at the patient's bedside, we are usually able to state positively that the suspected case is or is not one of acute ileus. We have seen definite instances in which such patients have come to operation six to twelve and even twenty-four to forty-eight hours earlier than otherwise would have been the case

DISCUSSION

Dr. F. K. Herpel, W. Palm Beach:

Time does not permit a very elaborate discussion of the many points touched on by Dr. Feaster. And it is not necessary at this time to make any comment on the necessity of a roentgenological consultation because all progressive surgeons and internists are increasingly using the roentgenologist as a consultant rather than as a technician.

May I cite one case bringing out a point which was not covered by Dr. Feaster. Several years ago, while practicing in a far western city, I was called one night about eleven o'clock in consultation to see a ten month old infant. This child awakened during the night crying with pain. The abdomen was palpated and found to be rigid. The child did not have any material elevation of temperature but was obviously sick. Realizing that the diagnosis of pnenmonia might be complicated by the presence of abdominal pain an examination of the chest was suggested both by the surgeon who had seen the child and by myself. Examination of the chest, however, was entirely negative. However, upon fluoroscopic examination a common pin was found lying in the region of the duodenum. As in most right-sided abdominal conditions found in small children a strong possibility of appendicitis was considered and the surgeon was at the point of doing an operation for acute appendicitis at the time I was called. The abdomen was opened, and on making

an incision through the peritoneum a common pin was found lying between two adjacent loops of small bowel. Most unfortunately the pin had perforated the first portion of the duodenum. Convalescence, however, was uneventful in spite of the fact that the duodenum had been perforated.

I am firmly of the opinion that if this child had been operated on for appendicitis through the usual incision, this pin, located in the upper abdomen between small bowel loops, would not have been found. I do not believe that a surgeon would do much manipulating in the abdomen of a child of this type.

I simply mentioned this because it was not covered by Dr. Feaster. I am sure he has encountered more than once instances of foreign bodies in the intestines of small children.

I wish to thank Dr. Feaster for the opportunity of discussing his paper.

THE NEED FOR SANATORIUM BEDS IN THE CONTROL OF TUBERCULOSIS*

ARNOLD S. ANDERSON, M.D.,
St. Petersburg.

Tuberculosis is the greatest social and economic disease problem that we have today. Each year in the United States 85,000 people die of the disease. Three out of every five deaths in girls between 15 to 30 years of age are due to tuberculosis. These simple figures are enough to acquaint us with the fact that this is by no means a conquered disease. It is still the king of killers among people 15-45 years of age. The magnitude of its destruction is due to the fact that it is a contagious disease. In dealing with this subject let us keep that in mind. Only by so doing can we hope to aid materially in solving it.

Let us first remember that the two prime requisites for the combating of any contagious disease are education and isolation. By education we attempt to place before the public health facts that will help people to a better understanding of right living. It is, of course, a question of how seriously the average adult takes advice regarding more wholesome living habits. He usually prefers to leave the practice of that to the other fellow. Aquaint him, however, with the fact that beside him lurks a dangerous and deadly disease, that if it continues to linger, it will strike him, and you find that he is exceedingly anxious to provide for himself a cleaner environment. He wants the source of infection removed to a place remote enough so that he may carry on unmolested. If health education does nothing more than stir up the understanding of people regarding the dangers of contagious diseases and the need for their isolation, it serves a great purpose.

The isolation of the infectious tuberculous patient has been a problem of long standing. During the latter half of the eighteenth century European countries were gravely concerned over it. Italy, recognizing its importance, enacted a drastic law which provided that a physician failing to report to the Board of Health a known consumptive should be fined 200 ducats (about $450.00) and suspended from the exercise of his profession for one year for the first offense; and in the event that he failed a second time, he should receive a fine of 400 ducats and exile for two years. The house in which the patient had lived had to be completely renovated and his personal belongings destroyed by burning. When one remembers that the diagnosis of tuberculosis at this period was a thing of great uncertainty—before the advent of the x-ray and the discovery of the tubercle bacillus—one cannot help but feel that much injustice must have been done to those having chest conditions not tuberculous but simulating it. Isolation was accomplished by rigid quarantine of private homes.

Today we find the sanatorium as an important means of isolating the infectious tuberculous. The value of such institutions first gained recognition at the time of George Bodington in 1846. He courageously departed from the bleeding and physics treatment of the day and introduced open windows and good food. He established the first institution in England for the care of the tuberculous. Opposition, however, to this radical departure from accepted methods was so great that the sanatorium idea failed and the institution was converted into a home for the insane.

Dr. Herman Brehmer of Germany was the first to make a success of the sanatorium. He was followed by his pupil and patient, Dr. Peter Dettweiler, who more than his predecessor stressed the importance of rest for the tuberculous.

Dr. Edward Trudeau pioneered the sanatorium idea in the United States and it was, to a great extent, through his guiding influence and enthu-

*Read before the annual meeting of the Florida Tuberculosis and Health Association, Jacksonville, April 30, 1934.

siasm that the sanatorium achieved its beginning popularity in this country. From the time of Trudeau's first institution, 1884, until the present there has been a steady increase in sanatorium accommodations until now we have over 72,000 beds in the United States for the tuberculous.

This very brief mention of the development of the sanatorium movement is given for the purpose of emphasizing the fact that the use of such beds is by no means a new and untried theory as an aid in the attempt to control the tuberculosis problem. Over a period of eighty years the sanatorium has become recognized as a vital and necessary adjunct in the battle against this dreaded disease. Today the concept is fast becoming crystallized that the sanatorium is first and foremost a place for isolating the infectious tuberculous—it is a guardian of the public health; second it provides the most effective means of treating the tuberculous patient and restoring him to a useful life.

In order to appreciate the importance of sanatorium beds in the control of tuberculosis let us consider in some detail these two mentioned functions.

To find and isolate an infectious case of tuberculosis means that we are removing from the community a spreader of disease. It has been estimated that the average open case infects with tubercle bacillus at least seven other persons in the community during the life of that individual. If that is true we can readily see how necessary it is to find and remove early those who serve as disseminators of the disease. To do this effectively it is essential that the health department and the sanatorium be linked together as closely as possible.

The epidemiological service and the police power invested with the health department makes it the indispensable agency for handling any contagious disease and for that reason it would seem advisable to have directly under its supervision institutions for the care of the tuberculous. This would permit of a field service that could use the sanatorium as a quick and efficient means of isolating those needing segregation. Without such a service the sanatorium is doing only a part of its necessary work.

The second function of the sanatorium is concerned with the treatment of the tuberculous individual. Two things are essential here. First, the patient must be taught enough facts about the disease to make him recognize and practice such precautions as are necessary for preventing the spread of the disease to others. He also must learn enough about the nature of tuberculosis to help him in healing the lesion as soon as possible. This educational feature of the cure is of vital importance to the best therapeutic results. Second, every known means, medical and surgical, must be made available for the patient in order to aid in his recovery. The proper application of the rest treatment, good nourishing food, comfortable surroundings, and the use of collapse therapy in selected cases are all necessary in bringing to the patient the desired results. When these measures are used at their best the patient is reurned to his community within the shortest possible period of time. He may again take his place as a useful citizen.

The number of sanatorium beds necessary in the tuberculosis program depends upon the following factors:

1. The number of tuberculosis cases or deaths in the community.

2. The environment to which the discharged patient is permitted to return. With good home conditions an earlier discharge is permissible and so a more rapid turnover of sanatorium beds is allowed.

3. The type of care received at the institution. Where good medical and nursing care are obtained and where surgical facilities are at hand for collapse therapy, a goodly percentage of patients are made ready for earlier discharge than would otherwise be possible. In the Minnesota County Sanatoria for the year 1932, approximately 35 per cent of the patients received some form of collapse treatment, a fact which permitted a much more speedy return to the home environment.

4. Organization of the work as a whole determines to a great extent the number of beds required. Efficient supervision of the field service, and the admission and discharge of patients will help considerably in making a more rapid turnover of sanatorium beds.

It has been estimated that generally speaking, two beds for each tuberculosis death in the community is required to accommodate the needs of a locality. Formerly the ratio of one bed for each death was thought sufficient but later experience has shown that that hardly fills the needs.

In the state of Florida during the year 1932 there were 1,093 deaths due to tuberculosis. There are 274 beds in the state. If we take the

old ratio of one bed for each death we find a shortage of 820 beds. It is safe to say that the control of tuberculosis can hardly hope to be attained with a lack of such an important item. We need sanatorium beds for the isolating of sources of infection and for the treating of the tuberculous sick; otherwise disease spreads and continues to advance.

But while we are stressing the necessity for such beds let us not forget that of prime importance is the development of a plan which will oragnize all aspects of the tuberculosis problem. Unless these beds are utilized in an efficient and orderly manner such as is possible only through a properly regulated field service, their value is minimized. A plan for tuberculosis control is necessary that considers each locality of the state as a unit of the whole. Tuberculosis is a state problem rather than a county one for a tubercle bacillus can cross a boundary line insidiously and without respect for geographical limitations and so its spread must be attacked by state forces rather than by local ones.

A plan for the control of tuberculosis in Florida will take into consideration the organization required for finding and removing sources of infection as well as the number of beds required for those needing care. It will recognize the necessity of bringing into harmony all those forces in a community that can be instrumental in working toward a worthy end. It will bring clearly into view the fact that it is much more economical to prevent a case of tuberculosis than treat it. The thousands of dollars spent in an intelligent plan for controlling tuberculosis is but a pittance compared to that required for treating decently those who otherwise would develop the disease.

It is now over fifty years since the cause of tuberculosis, the tubercle bacillus, was discovered and that the disease spreads from person to person by virtue of this organism. We have learned about means of preventing its spread. We know that if we remove a person from an infectious environment before he becomes infected with the tubercle bacillus he will not develop the disease. We have amassed much knowledge, which if practically applied, would sink the death rate of tuberculosis down to a minimum. But so far we have failed to profit fully from it. The application of the facts have been far behind the realization of their worthiness. And so again we recognize the truthfulness of Tennyson's dictum, "Knowledge comes but wisdom lingers."

THE PREOPERATIVE AND POSTOPERATIVE MANAGEMENT OF SURGICAL PATIENTS WITH MENTION OF CHOICE OF ANESTHETIC*

J. Ralston Wells, M.D.,
Daytona Beach.

Lord Moynihan's phrase, "Modern aseptic surgery has made the operation safe for the patient; it is now the aim of surgery to make the patient safe for the operation," is truer today than when first spoken by that great English surgeon. To have a patient survive a major operation is not an achievement, but *how* that patient progresses, and the benefits he receives because of surgery, is the concern of present day surgery. The mere technique of an operation may be difficult at times, and requires the memorizing of the various steps as laid down in a text book. Poor preparation of the patient, however, may spell success or failure in any given operation; or careless postoperative care may nullify an otherwise brilliant success. In addition, surgical judgment, accompanied by surgically trained handling, may cause a simple procedure to suffice and produce better results than a spectacular major operation undertaken without adequate study and preparation. A test for a surgeon is knowing when to, and when not to, operate, rather than how to operate. I would far rather trust the surgeon of fair operative ability, using intelligent, careful, preoperative and postoperative treatment, than the one of careless preoperative and postoperative attention but brilliant table technique. An emergency operation is never enough of an emergency to do away with the major preoperative laboratory and hospital procedures. Certainly in an operation of choice (deliberate operation) the patient should never enter an operating room within a few minutes after arriving in a hospital. Such procedure is to be rigorously condemned. Because some operators "get away" with such procedure is no argument in its favor; it may be a stigma not only upon the operator but upon the profession of surgery in general, and bring harm to the patient.

To be able to deal with complications is necessary, but to know how to avoid these conditions requires a higher degree of surgical skill. There is no way for a young surgeon to learn these pitfalls better than by the side of a careful, kindly,

*Read before the Thirty-Fourth Annual Session of the Chattahoochee Valley Medical and Surgical Association, Radium Springs, Albany, Georgia, July 10th-12th, 1934.

and yet exacting, conscientious senior. They cannot be learned from books, and are far beyond the realms of "horse sense."

Above all, we must remember the surgeon is, or should be, an humble personage; the patient is the important actor, and all others are subordinate. A failure, or a success, with any one patient, judging from end results, will very often convince the most skeptical of this fact.

Preoperative preparation starts with the surgeon and his associates, including his assistants and nursing staff. Aside from the added pleasure to all when working in harmony, the patient receives the benefit of this cooperation. It is feasible and practical to maintain an attitude to your subordinates of kindness and consideration. The attitude of false superiority, or being "high hat", if you will, is mentioned only to be condemned. This attitude is generally only assumed, however, by the operator of little experience in order to "put something over" or under the false idea of "making an impression." Therefore, I place thorough understanding and cooperation, one with another, between the surgeon and his working associates as of prime importance in both preoperative and postoperative preparation and care. If juniors had the knowledge of their seniors they would not be juniors. Knowledge is acquired, and takes time, but cooperation and understanding can be had at the onset by all concerned and should be cultivated, starting by example and precept of the surgeon. A feeling of comradeship is essential; a dictatorial manner is very often a cloak for ignorance.

A thorough physical examination and an accurate diagnosis are necessary. A local deformity or pathological condition may be understood but the corrected results of this, no matter how skillfully operated, may rest entirely upon some distant irregularity of the general economy. Remember that the saying "a surgeon buries his mistakes" may not be an idle phrase, and may not reflect upon technique, but upon a careless physical examination, or a lack or regard for laboratory findings.

There are two great classes of operative surgery: those requiring emergency operations to save life itself, and those of choice to rehabilitate, or to correct conditions, for which there is more or less time at our disposal in which to make adequate preparations.

The Emergency Operation.—Unless we are dealing with an acute accident, rapidly oncoming shock, or hemorrhage (internal or external) there is adequate time for a history of past or influencing conditions and a urine and blood examination. The history very often must be obtained from a third party, and may be of no value. On the other hand, it may be the means of avoiding a complication or mistake. For example, an apparent acute appendicitis, if preceded by a cough, or even a severe coryza, may well be a right basal pneumonia with referred abdominal pain. A strangulated hernia of small size may readily be confused with appendicitis. On the other hand, a psoas abscess, not complete, may need immediate operative relief, and be confused by a diagnosis of ureteral stone. In like manner, a ruptured gastric, or duodenal, ulcer may be thought to be gall-stone colic. An adequate history will often indicate and avoid these pitfalls.

Routine blood and urine examinations should never be omitted, no matter what the emergency. If time is not sufficient to rectify a condition preoperatively, at least it is a guard against postoperative complications. Not infrequently, even during haste, preoperative measures may be taken —urine sugar, hypodermic of insulin; slow coagulation time, a hypodermic of a coagulant; severe anemia, a blood transfusion; severe nephritis, intravenous saline; and so on. How many of us have altered our diagnosis, and have avoided an emergency operation of an acute appendicitis when confronted with pus, or red blood cells, in the urine? Again, in emergency operations, a patient presenting a persistent vomiting, a long-standing diarrhea, or an evident acidosis, or other similar dehydrating conditions, may make an uncomplicated recovery by the rapid preoperative administration of water either intravenously, or under the skin, or both. The question of water balance will be taken up as we go on.

Operation of Choice.—Here the history is of even more value and the laboratory essential. The practice of medicine is that of deliberation, and surgery that of action. In this type of operation, surgery should be deliberate action and unless the surgeon is one of those men of rare qualities the help of an internal medical associate is both necessary and wise. It may take days, or weeks, to prepare a patient for a major surgical procedure, if for example our patient has an anemia, tuberculosis, slow coagulation time, severe nephritis, or one of several other basic conditions. From a medical economic viewpoint, this type of procedure, while of prime benefit to the patient, also offers a satisfactory solution

of the problem of adjustment of fees between the internist and the surgeon, the preoperative, and, after acute operative results permit, the postoperative convalescent period, rightfully going to the internist, with consultation of the surgeon if cooperation is ideal.

This preoperative preparation may be continued endlessly by multiplicity of generalities. In mentioning a few of the basic sound practices, the water balance has an important place, particularly if the kidneys are diseased. It is hardly possible to drink too much fluid, even if the amount is not being eliminated as gauged by the urine. If the output is 1500-2500 cc. per 24 hours, the intake is sufficient. On the other hand, if the stomach is intolerant, hypodermoclysis may be the route of choice, or rectal installations. Until the kidneys are secreting 1500 cc. or more per 24 hours, they should not be considered adequate. This question of water balance is one of our most important considerations, both in preoperative and postoperative management.

A condition that is not fully understood may be called "emotional imbalance." This term is not new, or original, but its portent is always capable of having new interpretations, call it pessimism, apprehension, premonition, fatalism, or what you will. This type of patient should be studied very carefully. An unlooked-for internal glandular secretory derangement, a nerve syndrome, a history of near fatality at a previous operation, possibly only a minor one, may be found and corrected, or avoided. Here the anoci-association of Crile is most necessary. I have found that the judicious use of bromides, small opium or barbituric acid doses, digitalis or strychnine, very often changes our outlook. The will to get well, I firmly believe, plays a great part on our ductless glands as aids to recovery; the reverse is likewise true.

Routine purging of the bowel, except in special cases, should be avoided. The nearer the bowels are to normal preoperatively, the better postoperatively. Two or three enemas in the twelve hours preceding operation are rational and adequate to free the tract of waste products.

It is not necessary to state that the patient should spend from twelve to twenty-four hours preceding operation in the hospital. Necessary laboratory work, local and general preparation, adequate sleep, and attention to the diet, are all a part of this phase of preparation. Judicious use of bromides are rarely contraindicated and a quiet nervous system is assured. A mild slow coagulation time may be speeded up by the use of dicalcium phosphate; a highly acid system be reduced by alkalies; a mildly rapid heart may be made less rapid and stronger by digitalis. This discussion will not permit preparation in special cases; for example, gastric resection, toxic thyroids, all clean bone, cranial, or kidney work. These are special subjects and must be treated as such. Do not fail to place all pediatric surgery in a special class also, because the surgeon overlooking this fact will come to grief many times.

The matter of blood pressure is one of wide limits and needs, with the exception of very high or very low, no special consideration. Moot's rule has been of little value to me in this connection. The extremes are readily taken care of in the general preoperative preparation. They usually are of special interest in the choice of anesthetics. The presence of syphilis, diabetes mellitus, and tuberculosis are not contraindicative to operation but should be noted and guarded against in postoperative care.

I have purposely avoided skin preparation, because this is part of operative technique. Tincture of iodine 7%, or picric acid 5%, are always dependable and inexpensive. The various new mixtures, unless the surgeon is able to check results bacteriologically, form a serious problem. Watery mercurochrome is of low bactericidal power; tincture of metaphen apparently is of value, and does not readily form a burn. This is a subject for more general discussion.

Posoperative Care.—To avoid the majority of the postoperative complications, attention to the foregoing preoperative points will be found helpful. The normal postoperative procedure should be of two kinds: keeping natural laws, and watchful, careful, and minute attention to detail. An intelligent nurse's chart is invaluable. A careless chart is not only of little value, but may be misleading and dangerous.

Our postoperative care depends to a great degree on anesthetics, or combination of anesthetics. Massive collapse of the lung is thought by some surgeons to be always present. Attention, therefore, to the kind of air, and the amount, is important. Cold, damp air, congested, over used and "stuffy" air are all to be avoided. Exposure of the chest, abdomen, or extremities, should not be allowed.

The Water Balance.—Obviously in most operative cases, with notable exceptions of thyroid, amputations, and bone work, water by mouth is not desirable. The stomach absorbs very little

water per se. Water by rectum is logical. I disagree with many surgeons, and condemn the "drip method" in any form. It is hard to maintain, expulsion by the patient is often hastened by the irritation of a tube in the rectum, and whether any fluid is expelled or not, it is difficult to accurately measure the intake. Above all, it is decidedly uncomfortable to the patient. Having had the personal experience, I am in a position to speak feelingly. Any persistent discomfort in the first hours after an operation may give us a restless, nervous patient. I use the small enemas entirely and find that four ounces of fluid, repeated every three to four hours, will be retained until the stomach can be relied upon. I have found that when the stomach is retentive, the rectum will expel and rarely before. My routine procedure is to give one pint of tap water immediately after operation, followed in four to six hours by regular installations of four ounces every three hours until the stomach retains it without nausea.

Position in Bed.—The position assumed by the patient is based upon entirely different premises than a few years ago. The disease and age are usually the considerations rather than the kind or position of the wound. Three main positions used, aside from the usual dorsal recumbent, are the Fowler, Sims, and Trendellenburg. The cranial, neck procedures (thyroid), pelvic, or general peritonitis, are best in Fowler's position; gastro-enterostomies and many abdominal drainage cases are most adequately treated in Sims' position; brain, anemia of the brain, vomiting or unconscious patients, are often benefited by the Trendellenburg. The position of dorsal recumbent should not be allowed for long periods of time; a turn to one side or the other is of great value in preventing or relieving postoperative abdominal distention.

This condition can be avoided to a great extent by using only hot fluids until intestinal peristalsis is well established, avoiding the use of relatively unimportant drugs, including the stomachics, digestants, syrups, fruit juices, milk of magnesia, and any foods that contain nourishment that require many metabolic processes to be assimilated.

Postoperative ileus is a discussion of too much length to enter into here; suffice to state that gentle handling of abdominal contents, avoiding general operative shock and prolonged anesthesia, avoiding certain drugs, especially atropine, will often obviate this troublesome, and at times alarming, condition.

A discussion of proper postoperative conduct would be incomplete without mentioning the sedative drugs. Opium in the form of morphine, dilaudid and codeine, is a necessity. It is my habit to give these drugs soon after the patient leaves the operating table, so that the fading narcosis may be overlapped by the increasing opiate. Freedom of pain adds to the patient's morale, obviates unnecessary irritation of a depressed nervous system, and does not add to a slowed or absent peristalsis. Opiates should be given freely in adequate doses for the first twenty-four to thirty-six hours, postoperatively, and then gradually withdrawn as circumstances indicate. At times morphine sulphate apparently excites a vomiting reflex. For this reason I habitually use dilaudid which appears in my hands to be almost without this distressing symptom. Codeine can often be substituted for its stronger sisters. A fact which must not be lost sight of is that opium, especially morphine, used in small doses, repeated with relative frequency, is a decided cardiac stimulant and thus may perform a double duty if necessary.

The usual patient can easily withstand a two to three day relative starvation. Do not push food, rather let the patient push you. The return of the appetite is one of the best indications when to resume nourishment. Hot water and hot tea are the two best foods for the first forty-eight to seventy-two hours. More errors will be made in giving food too early than too late. When in doubt, do not give food.

Wound healing decreases for the first three to four days, then increases rapidly to the twelfth or fourteenth day, with firm aponeurotic repair at the end of the twenty days. With this in mind, the time for allowing the patient to get up can be easily decided. Patients who have undergone operations of purely muscle splitting at cross angles can with safety be allowed to leave the hospital in six or seven days (the small transverse abdominal appendix incision). When the operation has been the longitudinal muscle splitting of upper abdominal, or lateral abdominal, incision the patient may usually leave on the tenth or twelfth day; the same is true in lower abdominal operations; in hernia repairs, the twenty-first day. I have found the above a safe guiding table. This is of course for clean first intention healing wounds.

A word about anesthetics: It is the duty of all

surgeons to decide upon the anesthetic for each case, based upon the preoperative findings together with the kind of disease and location of the disease. The anesthetic must be fitted to the patient, not the patient to the anesthetic. I venture to make a sweeping statement, knowing a storm of criticism may result, and I will readily grant there may be exceptions due to individual cases, but preceding all general and many local, or spinal anesthetics, the patient should be given some form of sedative. The use of the various barbituric radicals have filled a long-felt gap. From the early days of veronal to the present, I have used one form or another of a pre-anesthetic preparation to allay sensory acuteness. Having used avertin, barbital, and sodium amytal, I have for the past two years found that nembutal (pentobarbital sodium) administered intravenously gives me the most satisfactory patients. It has quick action, is readily controlled as to dose, and induces sleep in from one to three minutes without dreams. Postoperative nausea is reduced to not over two per cent in all classes of cases. There apparently is no untoward effects if doses of less than seven and one-half grains are given, although I have given higher without alarm. The effects are short, giving not over three to four hours, but may be lengthened by the insidious use of dilaudid or codeine. The patient, if anesthesia is preceded by a sleep-inducing preparation, requires far less of the anesthetic; avoids the "stage of excitement," as well as the conscious physical shock of operating odors, noises, and sights. The pulse and respiration usually are kept on a normal plane, and kidneys and lungs are far less likely to give postoperative complications. The special operations usually require particular anesthetics but in general, short operations, chloroform or nitrous oxide-oxygen, with or without carbon dioxide, are excellent; for longer procedures ether or spinal anesthetics usually are chosen. In cases of intestinal inflammation, peritonitis, or obstruction, spinal anesthesia is that of choice, providing the patient is cooperative. Spinal anesthesia has long been a pet subject of mine, as I have used for over fifteen years a preparation of cocaine. However, in the past year, I have used several other preparations, which under certain circumstances seem to be more easily handled.

This treatise is unduly long but touches only upon the rudiments in the conduct of operative cases as I have seen them. The pronoun "I" may have appeared many times, but it is the individual opinion for which we all seek and not a rehashing of some stereotyped truisms. Some of these, to be often repeated, must be necessarily true, and are therefore repeated here, but only when they have been both tried and omitted, and have proved of basic value in personal experience.

SUMMARY

Preoperative: Staff cooperation; history completeness; thorough physical examination; accurate diagnosis; attention to laboratory findings; special measures for various types of cases.

Postoperative: Attention to preoperative care; attention to history and physical findings; attention to special measures for various conditions.

Anesthetic Choice: Using a pre-anesthetic preparation; fitting the anesthetic to each case.

SOME COMMENTS REGARDING THE PSYCHOTIC*

A. T. Cobb, M.D.,
Chattahoochee.

With your permission I shall digress from the usual routine in a meeting of this type and present some interesting observations and notations relative to our mentally ill. In all probability you and even my colleagues at this Institution may not agree with some of the statements I make. They are, however, my honest opinions formed from my observations and from study of available literature. If wrong, I am open for conviction.

It has been stated, "the mind is the human being in action." It can not be separated from the physical problems of any patient. Its study in the future will play a larger and larger part of the therapeutic efficiency and social usefulness of every physician. One person out of every two hundred and seventy in the United States is psychotic; two per cent of our population is feebleminded; approximately 75,000 new patients are admitted each year to State hospitals; more beds are occupied by mentally ill than those ill from all physical diseases combined. Is it then any wonder that preventive psychiatry should be and is truly the coming field of medicine? Psychiatrical training in medical schools is woefully inadequate and must be expanded if the graduating physician of today is to be properly equipped to practice his profession.

Within each and every one of us there are certain instincts, wishes and emotions attempting

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to direct our thoughts and action. Opposed to them are the ideals of the individual, the conventions and demands of his social group. If the latter win, the individual is able to adapt himself to his environment and belong to the so-called "normal" group. If not, he is psychotic. Heredity and environment are thus both playing a part —environment, I believe, the more important. In every community and about every physician are people, not now mentally ill, but definitely prepsychotic. There are the peculiar, seclusive, "shut-in" type, considered by parents as an ideal child, but destined to become a dementia praecox. The depressed phases of the manic depressive psychoses come from the moody, pessimistic, subject to periods of depression type, and the manic phases from the overactive, happy, talkative, "life of the party" individuals. It is the depressed individual who does himself bodily injury and many unexpected suicides are probably unrecognized depressed phases of manic depressive psychoses. Threats of or aborted attempts at suicide can not be lightly taken; another and possible successful attempt may follow. A most pathetic condition is a well respected family of comfortable means reduced to poverty, disgrace and shame and mentally tortured by the poor business judgment, shameless immorality, and alcoholic debauches of an erstwhile exemplary father and husband—an early paretic, unrecognized by family or physician. We can not expect or hope for the lay people to recognize these things. It is the burden and responsibility of the family physician who should recognize them, take proper steps, and offer correct guidance.

Certain psychoses have definite causative factors as those resulting from pellagra, syphilis, and the exogenous toxins, morphine and alcohol. The great majority are functional in type and have no definite physical background. Here heredity, instinctive and emotional forces, and the conflicts of life come into play more than in the usual physical conditions. Brain tumor, contrary to the usual belief, is a causative factor in only .2 to .5 of one per cent of cases admitted to state hospitals. The figures quoted were reached from autopsy findings in a large series of cases. Even when present diagnosis is difficult.

The economical depression has been frequently referred to as an important factor in causing an increase in mental disease. This is without foundation. Not withstanding the fact that because of this economical condition we now have many people admitted here that in normal times would have been cared for at home or in private institutions, we had admitted in the year 1929, one of fair prosperity, 1351 new patients and last year, the one of greatest depression, we admitted 1157, a decrease of 14 per cent. May I add the same refers to overwork. It does not cause psychoses but the mentally ill in the early stages, when making a desperate effort to escape an unsolved mental conflict, may show unusual physical activity.

Pellagra is a fairly common cause of mental disease, but the pellagra in many patients admitted is secondary to their mental condition. Particularly does it appear in the depressed conditions, where nourishment is poorly taken. Here a difficult differential diagnosis arises. Frequently time alone will tell. Pellagra comes from rural more than urban districts and by far most of it from the western part of this state. Using the white female division, over a period of the last three years as an index, I find that 69 pellagra patients were admitted. Twenty-nine per cent proved to be secondary to the mental condition. Seventy-one per cent came from points west of Tallahassee. Three adjoining counties of West Florida, namely, Holmes, Washington, and Walton, which make up 2 per cent of the state's population, furnishes us with 45 per cent of our pellagra. Hookworm disease corresponds very closely with this geographic distribution. Pellagra is a preventable dietary condition and is cured by proper diet. Our results in treating this condition are very good. We use a well-balanced general diet and find that Brewer's yeast and other vitamins are not necessary. Due to known fact that these people frequently have a low or absent gastric acidity we have used dilute hydrochloric acid in adequate doses, which are larger than the pharmacopeial one, to a good end in treating the accompanying diarrhea. This is likewise true in treating cases of diarrhea in which no definite pathology is demonstrable. In turn this suggests their origin in low gastric acidity.

The importance of focal infections as causes of mental disease has been and still is overestimated. I frankly do not believe that they cause many if any major psychoses. Mental patients are notorious for lack of care of teeth and body in general. Infected tonsils seem more common but they are results rather than causes. True it is that toxins play a part, alcohol and morphine as exogenous ones in particular, but to make a

diagnosis of toxic psychosis, the toxin supposedly arising from an endogenous point and without definite physical stigmata of an advanced toxic state, I can not. Watch those in whom a diagnosis of toxic psychosis has been made over a long period of time and you probably will be forced to change. When patients previously admitted and diagnosed toxic have returned in a definite clinical type of psychosis, we must conclude that we were wrong. These foci of infection may, in so far as they contribute to physical weakening, be considered as minor contributing factors, but the theory that they cause major psychoses has stood neither the test of time nor clinical experience. Many times I have seen patients with teeth more or less out, tonsils gone, or just over an abdominal operation, who had been promised health therefrom, but find themselves here because of an advancing mental state. Such incidents certainly give no credit to our profession. The surgeon who becomes quite elated in thinking he has cured a psychotic condition by removing tonsils or gall-bladder, or the dental surgeon by removing the teeth has probably failed to recognize the influence of Father Time which is, after all, the great factor in recovery of functional psychoses. These conditions which clear up quickly and completely are in all probability the first attack of a manic depressive, and if this same surgeon or dentist will treat his patient over a long enough period of time he will probably find his same patient in the same mental state but with no tonsils or teeth to remove.

Much along this same line may be said in regard to trauma. We do have traumatic conditions, but not near so commonly as the laymen and even some of our own members seem to believe. The reference of a mental condition to some injury in childhood and with many years of good mental health thereafter appears quite unreasonable.

Psychiatrical knowledge is advancing and we can no longer be contented with attaching psychoses to certain epochal periods of life. I refer particularly here to the so-called menopausal and puerperal psychoses. It must be understood and fully appreciated that the strains incident to pregnancy are great, but they are not true causes of mental disease but only precipitating agents in the outbreaks of various psychoses, particularly dementia praecox. White, a recognized authority, states "There is no such thing as puerperal psychoses, strictly speaking." Mental disorders should be classified according to symptoms produced and not to time it occurs. We would be as justifiable in making a diagnosis of "exposure" pneumonia in a definite lobar pneumococcic type. The same conclusion may be reached about the period of menopause. Here the onset of manic depressive and involutional conditions give rise to the erroneous opinion that they are the result of the menopause. Consult recognized modern textbooks of psychiatry, or the classification of mental disease of the American Psychiatrical Association, and I believe you will find very little, if any, recognition given to these so-called epochal psychoses.

Menstrual disturbances are common in mental patients. Much of this is due to debilitating conditions and is a protective mechanism such as we see in physical ailments. Carefully taken history will usually reveal the onset of mental symptoms before the amenorrhea. Here I would like to mention the necessity of a very discriminate use of Theelin or other such powerful stimulants to the female reproductive organs lest we aggravate an already mild or precipitate a potential psychosis. If we do not actually produce a major mental ailment we may only add to the mental suffering of those in whom the nervous state is the result of a long continued repressed sexual desire.

Those connected with mental diseases see much of the distressing condition of migraine. According to recent literature many of those cases are the result of vitamin deficiency and its resulting blood calcium disturbance. I am apparently getting excellent results in the use of Viosterol as a prophylactic for this condition.

There is a definite sex distribution of the psychoses. In accordance with the fact that the males take a greater part in the stresses and strains of life and at the same time enjoy more freedom we find the resulting psychoses as alcoholism, cerebral arteriosclerosis and spyhilitic conditions far more common in them. The affective psychoses as manic depressive are more common in the females. All in all, males predominate.

Drug addiction and alcoholism are common. They may come here, their tissues be freed of the toxins, and then released, but most of them are soon with us again. They do not possess sufficient self-control or will power to refrain from imbibing or they would have never been here the first time. Many belong to the constitutional psychopathic, never-do-well-anywhere group. Some cases represent symptoms of defi-

nite clinical types of psychosis, particularly the manic depressive. The drug addicts as a rule are the most pathological of liars, and cannot be trusted. They will go any limit or use any means of obtaining the drug when on the outside, to bring it into the institution with them or even to get it to a fellow addict, be it their own child. There has been discussion regarding alcohol as a predisposing cause of angina pectoris. In the light of recent literature this seems unlikely. I do not recall seeing this condition in any case of alcoholism here. A warning should be given in regard to the use of hyoscine in these or any psychotic lest we add a belladonna delirium to an already difficult situation.

Only a small percentage of epileptics are admitted to state institutions, but we have many. Little do we know about them and there is much we should know. Here exists a wide field for research. I have noted in my contact with them that hypotension and the lack of cardiovascular disease seems unusually common. Our therapy is discouraging except in the states of status epilepticus where I. V. sodium amytal is an effective and quickly acting remedy. The drug is potent and dangerous. It must be used only when occasion demands. In the normal individuals many hours of sleep follow injection of 15 grains. I have seen very maniacal patients sleep only thirty minutes.

The psychoses are relatively more common in the single and divorced, personality makeup preventing marriage in the first and prohibiting domestic peace in the latter.

Paranoid conditions are common but true paranoia is rare. The paranoiacs kill an unsuspecting and frequently innocent person upon whom they have attached their delusions. The praecox is the one who commits the weird barbarous crimes such as murder of their own entire family.

Surgery of the psychotic is different to a certain extent from surgery of the non-psychotic, but I dare say it is just as satisfactory and yields equally as good results. The cooperation of the patient and a smooth convalescence is the rule and not the rarity as one not accustomed would think. Some knowledge of psychiatry is a prerequisite and nurses trained in mental disease a necessity. The acute maniacal should not be operated upon unless necessary. The badly depressed individual is a poor surgical risk as he does not have a desire to live and difficulty in giving nourishment may be encountered. The cerebro-spinal syphilitic patients do not stand trauma or any type of anesthetic well. Spinal anesthesia is absolutely contra-indicated. This brings to mind that every surgeon should think of this possibility and examine the spinal fluid of every syphilitic before administering a spinal anesthesia.

Many feeble-minded people either are or have been married. In most instances their mate is feeble-minded, their families are large, and the earning capacity of the head of the family small. What chance do their children have? Poverty accompanies feeble-mindedness. Their number is ever increasing and sooner or later the poverty will not only affect them but every one in our state who must tax themselves to support and perpetuate these people. If our country can draft our choice and splendid young men to give their lives for the country and the welfare of the entire social group, I do not see where it is not justified in forcing these mentally unfits to become subject to sterilization or segregation. I am positively in favor of adequate sterilization laws in this state. Furthermore, some feeble-minded and other psychotics admitted are illegitimately pregnant, and I firmly believe there should be legalized abortions in these cases before viability and to be done in the state hospital after their sanity has been passed upon by its examining board. It would seem to me to be relief for the mentally incompetent and their already burdened family and mercy for an unborn child.

In my mind it is the patriotic duty of every member of our profession to make of himself a leader in the recognition and prevention of these mentally ill and encourage the passage of such laws and measures as will stop this ever-increasing burden upon our taxpayers and which, if not controlled, may ultimately undermine the stability and intellectual greatness of our country.

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FLORIDA ONE OF TWO STATES HAVING LAY SUPERINTENDENT AT STATE HOSPITAL

An extremely grave situation now presents itself with regard to the State Hospital for Insane at Chattahoochee. The chain of circumstances producing the abnormal and wholly illogical arrangements for the conduct of the hospital have been inexorably forged by the responsible authorities since the death of Doctor Folmar, the last medical superintendent to serve at the institution. These developments have been so at variance with well established and proper methods of institutional management that the future of the hospital and its inmates has unquestionably been placed in jeopardy. Their defense and protection is wholly now in the hands of the medical profession, upon whose courage and initiative rests the hope, both of the reformation of the conduct of the institution and the care of the unfortunate human beings behind its doors.

A summary of the dubious circumstances which have characterized the plans of the hospital control and management have been given you in a recent article in this Journal. More recent developments give promise of such hazardous impairment of the welfare of the institution and its unfortunate inmates that the profession as a whole should be thoroughly informed in all the disturbing details.

It must be remembered that most of the recent acts of those in control have succeeded their study of a report of the National Committee for Mental Hygiene, following a complete and exhaustive survey by the latter, said survey having been requested by the State of Florida. The report contained a number of strong recommendations as to management of our largest state institution, and urgently recommended the appointment of a medical superintendent. It is the apparent tendency of the Board of Commissioners of State Institutions to completely ignore this recommendation, that impels us to place in the hands of the entire medical profession all of the facts.

Details of the management of the State Hospital should be of most vital concern to the Board of Commissioners of State Institutions. They are dealing here, not with a prison camp or a reform school, but with what should be a highly and efficiently organized medical institution charged with the care and treatment of over four thousand of the most unfortunate human victims whose illness and not crime places them in the supposed humane and compassionate charge of a great state. To give political consideration to the plan of administering to these invalid charges is not only basically illogical, it is cruel, it stains the name of the State, and gives rise to grave question as to the motives of an administration condoning such a procedure. The first and last, one and only, consideration facing those in authority over such institutions is the medical care of those mentally sick that it houses. Any deviation in the slightest degree from this consideration constitutes a willful betrayal of these thousands who are sick, and who are deprived of liberty and are powerless to raise their hands in self defense.

Let us see briefly what circumstances have arisen recently that might justify us in questioning the acts of our Board of Commissioners of State Institutions. Doctor J. Q. Folmar, the medical superintendent of the hospital, died on duty in 1932. Doctor J. H. Pound, resident surgeon there, was made acting superintendent. He stated he did not wish the superintendency because he believed he was not equipped to serve in an administrative capacity and did not desire to abandon professional effort. A short time later Mr. Thomas, then Purchasing Agent of State Institutions, Tallahassee, though in ill health, was appointed superintendent. He assumed the position but was too ill to serve properly in that capacity. During this time the Florida Medical Association, obviously concerned with such a condition involving the care and

treatment of these unfortunates, appointed a committee to study the circumstances and make proper recommendations to the Board of Commissioners of State Institutions. The committee was appointed at the meeting of the State Medical Association May 1st, 1934. Some weeks later it developed that a lay superintendent was about to be appointed. On July 14th the committee sent copies of its findings and recommendations to the Governor and his cabinet, who constitute the Board of Commissioners of State Institutions. In these recommendations it was set forth in detail the numerous and convincing reasons for the appointment of a doctor of medicine, trained in psychiatry. It was naturally assumed by the committee that the survey of the National Committee for Mental Hygiene, which had been placed in the hands of the Board of Commissioners of State Institutions, had been perused and its incontrovertible findings and unbiased recommendations, especially that a doctor head the hospital program, had been given credence by the Board. Apparently the valuable advice of the National Committee for Mental Hygiene was "a scrap of paper." The survey was a wasted effort.

The committee was informed that a lay superintendent had been appointed. We were informed that Mr. J. H. Holcomb, Superintendent of St. Luke's Hospital, Jacksonville, had been tendered the appointment. Contact with Mr. Holcomb developed the fact that he had declined to accept the appointment. Telegrams were then sent each member of the Board urging them to reconsider his arbitrary stand and to follow the strong recommendations of the National Committee for Mental Hygiene, international authorities on this question, and to appoint a highly trained physician as superintendent. Every effort had previously been made by the committee to develop in the Board a thorough understanding of the many special problems involved, a realization of the State's responsibility to the hospital inmates and how these responsibilities could be most easily, efficiently, and humanely discharged, but to no avail. One member of the Board expressed himself as being tacitly in favor of a medical superintendent, but was entirely misled by a completely false statement that over half of the state institutions for the insane in this country were presided over by lay superintendents. He then joined in a unanimous vote to appoint a lay superintendent.

Colonel Preston Ayers of Orlando, therefore, became the hospital's head and assumed the responsibility of superintending the State's medical care of four thousand humans suffering with that most dreadful of all maladies, and lingering in the perpetual haze which bars them from intellectual and social intercourse with fellow human beings. The Colonel must have had grave doubts as to his capacity for performing the complex, special, and highly technical duties placed upon him.

In referring to Colonel Ayers the writer is doing so in a purely impersonal way. He has had acquaintance with Colonel Ayers in a military comradeship and has a high regard for him. This comment is not directed toward the office holder, but against the method by which these offices are filled.

It is probable that the Board of Commissioners of State Institutions will defend its action of having appointed a lay superintendent to direct the affairs of the greatest hospital in Florida by emphasizing that the hospital needs a business manager and that the medical department can function under the direction of a lay superintendent.

"While it is appreciated that many phases of mental hospital administration require per se no special medical training, there are, nevertheless, medical and certain psychiatric implications in every duty of a mental hospital superintendent. Even such non-medical functions as the ordering of equipment and supplies incurs professional understanding if the welfare of the patient is to be best served.

"Then, of course, the accord of hospital personnel is of prime consideration. Experience has taught that physicians are enabled to give their best services under the direction of an administrator with a thorough understanding of the medical viewpoint. Constant friction is to be expected in an institution where the work of physicians is to be influenced by orders from a layman. No such institution can expect to attract or hold for long the best type of medical personnel."*

So, we sat by and saw the drama enacted. We doctors cannot be blamed for feeling that our state hospital has been placed in the category of a prisoners' stockade, or a penal institution, and

*Letter from H. Edmund Bullis, Executive Officer in Charge, National Committee on Mental Hygiene, Sept. 7, 1934.

that a lay warden has been given police duties over the thousands of lives engulfed in stark tragedy.

The Board of Commissioners of State Institutions alone is responsible for the grave dereliction of duty to our public charges at the State Hospital. They alone are answerable for actions wholly at variance to those practiced elsewhere in the United States, for the care and protection of the curable and incurable insane. They assume the position of authorities superior to that great group of philanthropists, the National Committee for Mental Hygiene, who, without compensation or hope of reward other than serving a great class of unfortunate human beings, have given largely of time and effort to develop the best methods for caring for those who otherwise would be forgotten.

Just what does this arbitrary action of the Board of Commissioners of State Institutions mean? Of the one hundred and seventy-five state institutions in the United States, all but two, and one of the two is Florida, have trained psychiatrists as heads of their institutions for the treatment of mental disease. Must Florida continue to stultify itself by denying to its unfortunate mental charges, the management and care found uniformly to be the best and most humane elsewhere in the entire United States? Must Florida continue to suffer its largest institution to be a political football? Only the Board of Commissioners of State Institutions can answer.

(Signed) RALPH GREENE, M.D.

RADIO BROADCASTS, 1933-34

The following broadcasts were arranged by the Public Relations Committee of the Florida Medical Association and given over station WRUF, Gainesville:

GROWTH, DEVELOPMENT AND MATURITY*

DOUGLAS D. MARTIN, M.D.,
Tampa.

Growth and development are largely interchangeable expressions, though they have a differential significance in child studies. Growth is increase in dimensions; development is a gradual progress toward maturity. Senescence is the decline toward old age and senility: growth naturally presupposes development.

Child life can be divided, for the purpose of description, into the antenatal, neonatal, preschool or runabout and the school age.

Observations have been made on the growth of children from time immemorial, but after all, we have to use some general standard, and this is usually spoken of as the average child. Therefore, the average has to be our guide. Yet, when we compare the average against the given child, we may find wide variation. Then our duty to the individual child is to find out how far he or she may deviate from the average and still be a normal child in growth and development.

How many times have we heard the expression, "Mrs. Jones' baby weighs five pounds more than my baby, and I just can't see why." Well, probably Mrs. Jones cannot see why, but there are many things to be considered in the growth, both mental and physical, of every child.

First, the racial characteristics have to be carefully considered and there is no doubt that racial characteristics in certain geographical locations play an important part in the stature of a great many of our population throughout the world. There is always to be considered the family in paternal growth in children, this being true of one family through several generations. Body types have to be considered, whether the individual child is a lineal type, that is, tall and thin, or a lateral type, short and stubby. This may go down through several generations, true to type, then miss one generation and the opposite condition exist. We certainly must give consideration to this type of growth, and to a great extent it is poorly understood; as far as we know the cause in undetermined.

Certain family traits and manners will be transmitted through several generations, then miss one generation, and engender an entirely different individual, "for better or for worse," so after all we can never safely predict a genius or a "nit-wit."

We must always bear in mind that given two individual children of different, or the same family, the feeding and nutrition of one being as nearly correct as it is possible, the other fed poorly and not properly cared for, at the end of the third year, we have an entirely different picture. The properly fed child will be spoken of as our average child in growth and development, while the poorly fed child will show certain characteristics that will indicate weight and de-

*Radio broadcast delivered under auspices of Florida Medical Association over Station WRUF, Gainesville, October 29, 1933.

velopment under the average, and the possibility of mental retardation.

Now let us bear in mind, please, that our normal child might in all respects be a normal child, but, with weight and height below the average. Therefore, do not get excited and think you have a child that has to be pampered, gorged, treated and stretched to increase weight and height; let nature take its course, and after a few years you will find your child is not so far removed in development from what is termed the average.

We have discussed growth in the normal child or the child we think of as the average. There are other children that are afflicted with glandular dysfunction that either fail to grow at the proper ratio, that grow too rapidly, or that fail to develop mentally. These children are all so far removed from the normal in their care and treatment, that it is necessary for them to be under constant supervision and have competent medical care. They are not without a ray of hope and modern medicine has made wonderful progress in the treatment of these unfortunate children.

A word about the average weight and height charts of our schools: I wonder at times if they are not more of a hindrance than a help to our parents. I know they certainly cause a great deal of anxiety to parents of this country. There are many other things to consider than height and weight before a child can be classified as below the average.

There is at least 50% more of a gain in growth and development in the first ten years of life than in the second ten years. There is, of course, greater growth before puberty than after puberty. This is noted in the skeletal or body growth, as most of this growth is accomplished before puberty. So the old adage of doing our corrections in our growth and development program in infancy and childhood holds true, because there the greatest help can be accomplished in correcting what might be termed "below the average."

During the era of medicine in which we are now living, there is no question that the greatest strides are being made in the care of our children, both in early infancy and childhood. Not necessarily more, but certainly better, babies, has been a slogan that has been well considered in the last twenty-five years. Of this fact we can readily be proud.

Parents should know that to accurately appraise a child, a series of observations are necessary. The children should be examined at regular stated periods. The children of today are our grown-up population of tomorrow. That growth and development may travel onward and upward, with as few set-backs as possible, the child should have the proper food and protection against certain diseases.

The parents of today's children are constantly being advised along educational lines, the necessity for protection against diphtheria and smallpox and, in older children, against typhoid fever. There is no need for me to further stress the great importance of the necessity of protecting our young ones against diseases that mean so much in the life of our children.

There are many parents who wonder why their children do not eat well and I will attempt to answer just a few questions:

Mrs. P. J. wants to know why her little girl will drink only milk, and will not take her vegetables and other foods.

Now, this question is a common and frequent one. In the first place, this child probably drinks one quart or more of milk every day. She is allowed this ideal food, probably as much as she wants, so consequently her digestive system is busy at work on the milk, and other foods have no attraction for her spoiled appetite. Now, milk is an ideal food and our children need it, but not at the expense of other good food. My advice to this parent is to discontinue the milk entirely until this child has acquired a desire for other foods which she should have to secure proper growth and development.

Mrs. F. H. wants to know if she should wait until her children start to school before having them protected against diphtheria.

By no means. Any time after the sixth month, this should be done. Don't wait until school age. The mortality rate in the first six years of life is greater than after the sixth year. The process is painless and the protection against the disease will give you fewer anxious moments, when your neighbor's child comes down with diphtheria, and your child has been playing with her the day before she was known to have it.

Mrs. S. M. wants to know when is considered the proper time to start orange juice and cod liver oil for her new-born baby.

By the end of the first month they should both be started and, of course, they should be given in small quantities and slowly increased so that

baby's digestive system can become accustomed to these new foods.

Here in Florida we are fortunate in having such a free gift of sunshine and out-door life the year around so that one of our most dreaded nutritional diseases, rickets, is a curiosity rather than one of everyday occurrence as in some of our less fortunate sister states.

Where growth, development and maturity are properly taken care of, and the simple rules of eating, sleeping and play are even partly followed, we will find that old age will come as a pleasure, with a body that will, in the decline of life, slowly cease its normal function at a ripe old age. We can say that a life has been well and judiciously lived and our duty well performed, making room for another generation that will start anew the process of growth, development and senescence, with even greater knowledge than that attained by our present generation.

THE MECHANICS OF POSTURE AND LOCOMOTION*

J. Knox Simpson, M.D.,
Jacksonville.

One of the most striking things about modern inventions to one who is familiar with the intricate structure and mechanisms of the human body, is the similarity of various man-made mechanisms to those which are in operation in one's own body. Most of the mechanical devices which we consider so marvelous are but crude replicas of similar apparatus which we ourselves carry around in sublime unconsciousness of their wonder and perfection. The inventors of the appliances which we consider so remarkable have probably usually felt that they were producing absolutely new things and utilizing new principles, without once stopping to think that the Master Inventor of all time had included in the human body perfected mechanisms of which theirs was but a poor copy. The human eye and the camera, the ear and the radio receiving set, the larynx and the loud speaker, are a few of the fascinating subjects of comparative study which so intrigue us.

In considering the subject of the mechanics of posture and locomotion I feel that it might be of interest to my hearers to have discussed in an analytical way, the locomotion of the human machine as compared with that of the most universally used modern means of man-made locomotion, the automobile; comparing principles and parts involved, to the certain defeat of even the most modernly perfected car.

Building the comparison from the ground up we find first that the widely heralded treads of the automobile tires, which furnish traction hold on the road and prevent skidding, are copies of the patterns of the ridges in the skin of the palms of the hands and soles of the feet which offer such wonderful holding surfaces to the primitive races who walk barefooted and climb smooth barked trees. The point in favor of the human tread is that it is automatically and continuously replaced as wear occurs, and it never gets slick and looses its grip on the road. The air in the tires of the automobile which must be continuously replaced and watched to keep it at the proper pressure to insure satisfactory cushioning is represented in the human machine by the pads of elastic fat forming the cushions of the heel and the ball of the foot. These retain their shape, thickness and elasticity without the help of anyone.

The controversy between the manufacturers of two widely sold and used makes of cars concerning the relative merits of mounting their springs crosswise or in line with the long axis of the car, is solved in the human car by utilizing both principles. There are two perfectly mounted semi-elliptic springs in the human foot, one placed transversely in the front of the foot constituting the transverse arch, and one from heel to ball, constituting the longitudinal arch. There is no squeaking nor rattling of the spring shackles on either one, and they never have to be sprayed.

The latest selling talk of one of the large automobile concerns is that their cars are equipped with knee action in order to take up the shock of irregularities under each wheel without transmission of the shock to the body of the car. They have given credit in this instance anyway, to the originator of the principle, by naming it knee action. One has but to watch the walk of a man with a stiff knee to realize how much shock is saved the human body by the action of the knees. Who has not, when a child, been able to jump from a considerable height without much jarring, by taking up the shock in the bending of the knees against the snubber action of the strong

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tendons in front of the knees and behind the ankles—Gabriel snubbers both, perfected to the nth degree.

The live rubber engine mountings of the car are duplicated to perfection in the human engine by the semilunar cartilages of the knee joint which form two perfectly elastic cushions upon which rest the lower end of the thigh bone in forming the knee joint.

In the overcoming of friction in moving parts the human body exhibits in its joints smoothness beyond comparison. If the surfaces become accidently scored, they are automatically smoothed off. The joint fluid is a lubricant which is manufactured in the joint itself, perfect in body and lubricating qualities, not subject to weather changes, kept automatically at the right amount, and replaced and renewed constantly as it becomes filled with the breaking down surfaces of the moving parts. We would probably be deprived of many entertaining radio programs if automobiles had half as good oiling and greasing facilities.

In the combustion of fuel and the generation of energy heat is always produced. In the car this is a very variable quantity and is controlled by the principle of irradiation of heat through circulating water through the air surrounded pipes of the radiator. In cold weather the engine is often too cold and in long drives it sometimes gets too hot. This is not true of the human engine. At rest idling or in high gear for long periods of time the temperature remains normal and constant at 98.3 degrees Fahrenheit by virtue of a perfect system of heat control. The circulation of the blood through the small vessels in the skin, the alternate widening or narrowing of these vessels, bringing more or less blood to the surface as occasion demands, with the moistening of the skin surface by sweat, adding as it does the principle of cooling by rapid evaporation of water, is all so perfectly and automatically adjusted that temperature variations in the human machine is an indication of trouble and is not normal.

The utilization of fuel by the engine of the automobile in the production of its locomotion, presupposes a long list of operations in varied localities—the production of the crude oil, its distillation, separation of waste products, refining of the gasoline, transportation to the filling station, thence to the automobile tank, the carburetor and on to the cylinders where combustion, energy production and giving off of waste occurs. This entire process is accomplished within the human engine, automatically and without any conscious effort on its part. The crude oil is poured into the hopper three times a day. There it is mixed and the process of extraction, simplification and refining occurs so that super-test fuel is constantly supplied. This is transferred by pipes to all parts of the body in exactly the proper quantities by a master pump, the heart, a fuel pump whose design and operation is perfection itself. In place of having one engine to drive the human car as does the automobile, with its single power station and transmission of power to the wheels, the human car has billions of engines. Each tiny microscopic cell is a complete engine, taking in fuel, combusting it, generating power, and giving off waste. The power is therefore applied at its source, without transmission, a principle which has been utilized somewhat in the four-wheel-drive car. Each of the human engines is automatic and capable of independent action, but all are grouped as a perfected whole, under the control of the master stations, the brain, the adrenal gland and the thyroid gland.

The human machine is a finished product. No new models are necessary. The old model continues each year to be far in advance of the newest models of the automobile world in all of its essential working parts.

Having now used a sufficient number of comparisons to show the similarity and the superiority of the human machine to the automobile as a means of locomotion, let us carry the comparison a bit further. What about the care which is necessary to the proper functioning of the two machines. Do you give your car better care than you do your own machinery? The human machine in all its grandeur of perfection, can and does wear out. It can and does have trouble occasionally. Are you as fair to it as you might be? Do you go at regular intervals to have its mechanism checked by your physician? Do you show less care and discretion about what you put into your stomach than you do about what you put into the gas tank or crank case of your car? Do you use less thought about what you put on your skin than you do of the cleaner you use on the paint of your car? These are very important questions for you to answer to yourself.

HOW WOUNDS HEAL*

T. H. Wallis, M.D.,
Ocala.

Today we are to discuss a very important function of the human body—one that is necessary and essential many times during life, and one that takes place daily before our very eyes—namely, how wounds heal.

There is nothing more marvelous in connection with the human body than the repair of wounds. In fact, it is so commonplace for one to cut himself or to undergo some surgical procedure that necessitates a cut or wound that we never question for a moment as to whether it will heal. We merely take it for granted that it will do so. And rightly so; for nature does intend and will make every effort to heal a wound. However, there are many factors that concern or influence the healing of wounds, and it is these influences and these conditions together with the actual process of healing that I am now going to attempt to make clear to you.

Every day either you or some of your friends are inflicted with a wound. No matter how small or how extensive it may be; no matter whether it is accidentally or intentionally produced (as by your surgeon) your body is called upon to repair the damage. At this time if we could but look within the wound and see what actually takes place we would at once be dumbfounded and astonished.

When an injury takes place there is a cutting or tearing of the skin and the tissue beneath. The cells of this particular place are cut in two by the thousands, blood vessels, and small capillaries are severed, as well as nerves and other structures.

What do we first notice? Pain, of course. After the pain we immediately look to see the extent of the injury, and there we find the skin lying open and profuse bleeding from the cut blood vessels. Together with this bloody flow we notice a pearish pink secretion, which is called blood serum.

Little do we realize that at this moment our body is already engaged in the process of repairing the wound. Most of us immediately apply a bandage or hot towels or various other remedies to stop the flow of blood or in other words make it clot. The clot is the very first step in wound repair. But! why does the serum and blood clot? This is nature's way of sealing up the cut ends of the injured blood vessels and furnishing a bridge work between the two cut edges in order that when new cells start to grow they may have a support on which to cross to the opposite side. This clot acts, we might say, as a cement between the wound edges, and while this is taking place, the near-by tissues of the wound are sending out large quantities of white blood cells to the injured area.

If we were to study this process under a powerful microscope we would find all the blood vessels about the wound very much enlarged and within them thousands upon thousands of white blood corpuscles, which are being sent as rapidly as possible to the wounded area. We ask: Why the white blood corpuscles? What good do they do?

Well, I often like to refer to a white blood corpuscle as a policeman of the body. No matter where a wound occurs we find in the blood vessels large numbers of white blood cells being rushed to the site of the injury, while in a normal person these cells are scattered over the whole body.

After an injury occurs, we find these cells, or policemen, if you please, coming out of their hiding places and rushing to the site of injury. They are ready at all times, and the moment trouble or necessity arises off they go to the scene of action to perform their duty. After arriving at the wound they have a definite function. They crowd themselves around and in the wound and stand ready to destroy any germ that may have entered the wound.

Now we have the wound cemented together with blood and serum and white blood corpuscles surrounding it to prevent any trouble. We are ready for actual wound healing.

Wound healing may take place in two ways:

1. By first intention (or as nature intended) which is the most desirable way.
2. By second intention or by granulation or in other words by the most undesirable way, although this may be the only possible way to heal in wounds when the tissues are extensively torn or bruised.

Let us consider healing by first intention or by the best possible way. Healing will take place rapidly in this manner, provided the skin edges are brought together firmly after first cleaning out the wound with antiseptics. In fact the skin

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may be held firmly together in 24 hours if this is done. The blood clot in the wound serves as a support to the connective tissue cells on the edges of the wound and these tissue cells immediately begin to multiply and form new tissues. These fibroblasts, as they are known, eat up large numbers of white blood cells that originally came to eat up bacteria and multiply so that new cells from one side of the wound interlace with new cells from the other side, forming a sort of spider web of new cells.

The near-by capillaries or small blood vessels begin to bulge and soon at the bulging point a new capillary develops. It, too, joins the new connective tissues to interlace with those of the other side. The clot is now said to be organized, meaning that it has new connective tissue cells and new blood vessels.

These fibroblasts begin to become elongated and string-like and develop into fibers. These fibers now begin to contract. As contraction takes place the fibers, being anchored to both sides of the wound, pull the wound edges together. As the edges become very close together the outer edges of skin or epithelial of the wound sends out new cells from each side to cover over the new surface and we have what is commonly called a scar, and complete healing of the wound in the best possible way or as nature so intended it. Wound healing by first intention exhibits no evidence of inflammation.

Let us consider healing by second intention or by granulation. Usually wounds of this type are either the ones with large cavities or loss of tissue or are wounds that have become infected and in which the edges have gaped far apart. It is called healing by granulation because granulation is visible. The actual healing process is identically the same as by first intention provided pus is absent. As a matter of fact, infection or pus is usually present. As a result of infection there is a destruction of adjacent tissue and repair cannot take place until this dead material is cast off. This process calls for a larger quantity of policemen or white blood cells and enormous number of fibroblasts and expenditure of considerable time. It requires longer for an infected wound to heal than for an incised wound to be repaired. An infected wound can heal by granulation only.

A short time after the infliction of a wound the oozing ceases and clot forms. Soon it is packed with white blood cells. In an hour or two the wound becomes glistening because of coagulation of fibrin of the blood. In a few days there is a marked discharge of pus. All this time the new cells and blood vessels are forming and trying to bridge over the cavity, but because of the infection present and because these cells are young and delicate, you can readily see that large numbers of these baby cells perish. As these cells are destroyed inflammation increases. In order to make up for the cells originally destroyed by the wound and those being destroyed by infection, it is necessary to have rapid multiplication and rapid growth. Gradually the new cells get the upper hand and bridge over the cavity, but in doing so it takes much time and a larger number of cells. This type of healing takes place from the bottom of the wound upward to the surface, and results in a very fibrous or thick scar.

As a result of this large area of granulation it is necessary for the skin or epithelial cells to multiply many times more than would be necessary had the healing been by first intention, because of the larger scar or greater distance between the skin edges. This process of healing by second intention consumes much more time and produces far greater scar formation than that of healing by first intention. The more scar formation there is the more contraction and as a result the more disfiguration.

You can now readily see that the main differences in wound healing is that by first intention it is as nature intended and results in little scar formation; by second intention or granulation, as nature did not intend it, resulting in disfiguring scar formation. It may be of interest to you now that you understand how a wound actually heals. to know of the various types of wounds.

Wounds are classified in the following groups:

First. Incised or clean-cut wounds, or one which is produced by an edged instrument such as a knife or a piece of glass. Such wounds do little tissue damage and have the best possible chance of healing by first intention.

Second. Lacerated or torn wounds resulting from a blow or a squeeze which bruises and crushes the tissue and ruptures the skin.

These are seen following our many automobile accidents.

Third. Punctured or penetrating wounds are made by pointed objects, such as knives, splinters and nails. The depth exceeds the surface areas. These wounds almost completely close when the

instrument inflicting it is withdrawn, hiding the damage it may have done.

Punctured and perforating wounds generally look the least harmful but they are by far the most dangerous. The nail wound is by far the most common in children. Most of us ignore it because it's small, and rarely is there pus. But it is within these punctured wounds that the deadly tetanus or lock-jaw germ thrives and lives only to strike after healing has taken place. In all punctured wounds lock-jaw or tetanus serum should always be given.

Penetrating wounds are almost equally as dangerous because it is impossible to visualize what injury has taken place in its depths. This type of injury often results in death when inflicted to the skull, chest or abdomen.

When such wounds are sustained the duty of the patient is to keep all foreign bodies such as cobwebs and tobacco out of the wound. Place a sterile dressing or a clean cloth over the wound and come to the doctor at once. It is the duty of the doctor to cleanse and disinfect the wound and so minimize or prevent infection; to restore the tissues to as near normal by suturing, so as to hasten healing and reduce to the minimum the amount of scar or deformity; then to administer antitoxins when indicated to prevent such serious infections as tetanus or gas gangrene.

If both the patient and the doctor perform their respective duties, not only will wounds heal quickly and without disfiguration as nature intended but many lives will be saved.

STATE NEWS ITEMS

Dr. Gerry R. Holden of Jacksonville was guest of honor at a dinner held at the Biltmore Hotel, Atlanta, September 15, by the officers and members of the Executive Committee of the Southeastern Surgical Congress, of which he is president. Plans were laid for the annual assembly of the Congress in Jacksonville next March.

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Dr. D. M. Adams of Panama City and Miss Mary Thompson of Ft. Lauderdale were married September 24th at Miami. Dr. Adams is a Tulane graduate and served his internship at the Jackson Memorial Hospital.

* * *

Dr. Frederick J. Waas of Jacksonville visited the Mayo Clinic during the middle of October. While on this trip he also attended the meeting of the American College of Surgeons.

At the call of President Homer Pearson, a meeting of the Executive Committee was held in Ocala, Sunday, October 14. A number of important questions were brought up for action.

Dr. Eugene G. Peek, General Chairman of Arrangements for the Marion County Medical Society, and Dr. Henry C. Dozier made progress reports. On the recommendation of the Marion County Medical Society, the Executive Committee designated May 13, 14, and 15, 1935, as the official dates for the next annual meeting of the Association.

Dr. Ralph Greene, chairman of the Committee on State Hospitals for Insane, appeared before the Executive Committee and made a progress report of his Committee.

Drs. W. C. Page, E. W. Warren and John McEwan made recommendations with reference to the meeting of the Railway Surgeons' Association which is held just preceding the Association's annual meeting. In order to provide time for special groups to meet previous to the official scheduled meeting of the State Association, the Executive Committee took action to have the First General Session of the Association convene at 4:00 p. m., Monday, May 13. This will provide sufficient time for special group meetings in advance of the regular program of the State Association. It was also decided to eliminate the usual smoker on Monday night and hold the first meeting of the House of Delegates at 8:30 p. m., Monday, May 13.

* * *

Dr. Stewart Thompson attended the Conference of Secretaries and Editors of State Medical Associations at the American Medical Association headquarters in Chicago during the month of September. This trip was made at no expense to the Florida Medical Association.

* * *

The following doctors attended the American Roentgen-Ray Society meeting held in Pittsburgh, September 25-28: J. C. Dickinson, Tampa; F. K. Herpel, W. Palm Beach; J. H. Lucinian, Miami; O. O. Feaster, St. Petersburg and W. M. Shaw, Jacksonville.

* * *

Dr. J. H. Chiles, formerly of Apopka, announces the opening of offices in the old Evans Studio Building at the corner of Main and Washington Streets, Orlando.

The Radiological Society of North America will hold its next annual meeting at the Hotel Peabody, Memphis, Tennessee, December 3-7, 1934. The medical profession is cordially invited to attend. Further information may be obtained by addressing the Secretary-Treasurer, Dr. Donald S. Childs, 607 Medical Arts Building, Syracuse, New York.

* * *

Drs. W. C. Bayless and Banks H. Goodale of Jacksonville enjoyed a motor trip to New York for two weeks in September. They visited in Washington, Philadelphia and Baltimore, returning by way of Luray, Virginia, through the beautiful Shenandoah Valley.

* * *

Dr. Julius C. Davis of Quincy recently spent a two weeks' vacation in the mountains of North Carolina.

* * *

Dr. and Mrs. E. J. Melville of St. Petersburg returned September 22 from a four months' trip around the world. They sailed from San Francisco for Japan, China, the Philippines, Australia and India.

* * *

Dr. and Mrs. D. Ward White of Miami Beach have returned from a two months' trip north, visiting at Binghamton, Niagara Falls, Lake George and Canada. While in New England, Dr. White visited several hospitals and clinics.

* * *

Dr. M. A. Lischkoff of Pensacola spent his vacation in Chicago and Rochester. While in Chicago, he attended the meeting of the American Academy of Ophthalmology and Otolaryngology.

* * *

Dr. J. R. McEachern, City Health Officer of Tampa, Dr. Noble A. Upchurch, City Health Officer, Jacksonville, Dr. Henry Hanson, State Health Officer, and Dr. Stewart Thompson, Director of the Bureau of Vital Statistics, attended the meeting of the American Public Health Association in Pasadena, California, during the month of September. Drs. Hanson and Thompson read papers before their Sections.

* * *

Dr. William E. Ross of Jacksonville spent three weeks last month on a vacation, visiting brothers in New York City and Boston.

Dr. Mederith Mallory of Orlando has returned from a three weeks' residence at Coronado Beach where he indulged in crabbing.

* * *

Dr. C. D. Hoffmann of Orlando spent three weeks in August visiting the clinics of Johns Hopkins University in Baltimore and the Woman's Hospital in New York City.

* * *

Dr. Max Ghertler of Miami has returned from a sojourn at Saratoga Springs, N. Y. He attended the laying of the corner stone of the Simon Baruch Research Laboratory by Governor Lehman.

* * *

Dr. and Mrs. W. A. Harrison of Ft. Myers have returned from an extended northern trip. They visited friends in various cities in Tennessee, New York, New Jersey, and Canada. They visited the World's Fair in Chicago and the Rotary Convention at Detroit. Dr. Harrison attended eye, ear, nose and throat clinics in several large cities.

* * *

Dr. J. S. McEwan of Orlando spent three weeks in September at the Mayo Clinic in Rochester. Shortly after his return, he made another trip north, which included a visit to Washington, New York and Baltimore. He attended the national meeting of the Aeronautical Examiners' Association.

COMPONENT COUNTY SOCIETIES

DADE COUNTY MEDICAL SOCIETY

A joint meeting of the Dade County Medical Society and the Dade County Dental Society was held October 5, at 8:30 p. m., in the Club Rooms of the Huntington Building, Miami. Papers on "Relation of Medicine to Dentistry" were presented by Frank Morrow, M.D., and J. Harold Klock, D.D.S. They were discussed by R. M. Harris, M.D., and E. V. Denault, D.D.S.

DE SOTO-HARDEE-HIGHLANDS COUNTY MEDICAL SOCIETY

The DeSoto-Hardee-Highlands County Medical Society held its regular monthly meeting at the Jacarando Hotel, Avon Park, Tuesday evening, August 14. Dr. C. H. Murphy of Bartow was guest speaker at this meeting. He presented a paper on "Syphilis" which was followed by interesting and instructive discussions.

DUVAL COUNTY MEDICAL SOCIETY

The first fall meeting of the Duval County Medical Society was held at 8:15 p. m., October 2, at the Mayflower Hotel, Jacksonville. In compliance with a resolution passed by the Society last February, the program was devoted to medical economics. Officers of the Retail Druggists' Association were guests at this meeting and were called upon for short talks on subjects that affect both the doctor and the druggist. Dr. Robert Baker gave an entertaining paper on "How to Practice Medicine and Still be Happy", which was discussed by Dr. Herrman H. Harris.

PASCO-HERNANDO-CITRUS COUNTY MEDICAL SOCIETY

Dr. George R. Creekmore of Brooksville entertained the Pasco-Hernando-Citrus County Medical Society Thursday evening, September 13. A full course dinner was served at the Tangerine Hotel, followed by a scientific meeting at the Hotel. A symposium on "Carcinoma of Cervix and Body of Uterus" was given by the following guest speakers of Tampa: Drs. W. P. Adamson, J. G. Dickinson, R. G. Nelson and William Rowlett. Dr. Adamson presented: "Responsibility of the Family Physician"; Dr. Nelson, "Responsibility of the General Practitioner"; Dr. Rowlett, "Injuries and Infections of Cervix and Uterus", and Dr. Dickinson, "Frequency and Mortality of Carcinoma of Cervix and Uterus", with lantern slides. An instructive general discussion followed the presentation of these papers.

POLK COUNTY MEDICAL SOCIETY

Members of the Polk County Medical Society and their wives were delightfully entertained Thursday evening, August 23, by Dr. and Mrs. Cordes of Frostproof.

The occasion was the annual picnic by the County Medical Society and the County Medical Auxiliary, a custom established a few years ago for the August bi-monthly meeting of the two societies.

This picnic was held at the American Legion hut on Lake Reedy, an ideal spot beautifully located. As the doctors entered Frostproof, Boy Scouts stationed all along the way directed them around Lake Reedy to the picnic grounds.

Target practice was enjoyed by some, swimming and boating by others and all enjoyed a fish fry served about six thirty. Everyone enjoyed the hospitality of Dr. and Mrs. Cordes.

WOMAN'S AUXILIARY

TO THE

FLORIDA MEDICAL ASSOCIATION, INC.

State Editor

MRS. S. M. COPELAND

1356 Willowbranch Ave.,

Jacksonville, Florida

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AN INVITATION

The Woman's Auxiliary to the Southern Medical Association will meet in San Antonio, Texas, November 13th to 16th.

Headquarters for the women will be in the St. Anthony Hotel where all meetings and functions will be held.

It is earnestly desired that our women of the South make every effort to attend this meeting "en masse." Your presence will not only help the meeting but will be a great inspiration to you yourselves. San Antonio is delightful and everything possible is being done to make your visit enjoyable.

A cordial and pressing invitation is extended to everyone to attend the Auxiliary Luncheon on Wednesday, Nov. 14th, to meet Mrs. Robert Tomlinson, National Auxiliary President and other distinguished guests.

* * *

The following items taken from the monthly news letter just received from Mrs. Robert E. Fitzgerald, national chairman of press and publicity, show something of what is being done in other states:

KANSAS

"We consider our biggest piece of educational work, the work of the Legislative Department. Our State Chairman investigated the Pure Food and Drug Act and has written a fine article on this subject, which was given at the mid-winter State Board meeting, and at many Civic Club meetings. The men's advisory board of the state asked us to investigate legislation and to make a map of our state, which would show the locations of the doctors and auxiliary members in respect to their representatives and senators. The auxil-

iary's duty was to bring out the feeling of the state representatives and senators in respect to the medical profession, on such questions as the Basic Science Law, their religion, their family physicians and their specialists. Much can be gained if we are informed as to these qualifications of the state representatives and senators. We know at once whether they are in sympathy with Christian Scientists and Osteopaths, or with the medical profession."

MISSISSIPPI

"Assistance was given to the State Board of Health by placing in the Women's Work of the CWA the project of teaching Hygiene and First Aid in the schools. This project resulted in the employment of eighty-five nurses for instruction purposes only, and several thousand children receiving instruction in health and first aid."

OREGON

"Since the organization of the Woman's Auxiliary to the Oregon State Medical Society a Basic Science Law was successfully passed in the 1933 Legislature. This act has long been fought for by the State Medical Society and defeated several times, but undoubtedly the assistance of the auxiliary finally brought success. While celebrating this great event for scientific medicine in Oregon, we were suddenly faced with the fact that a group of cultists with the lowest standard of education known had attacked our Basic Science Law with a petition to have it repealed at the general election in November. This would not be so bad if it were a simple repeal of the Basic Science Law but their petition embodies in itself an amendment to the Constitution of Oregon whereby all Medical Legislation and Health Laws heretofore existing are repealed and the practice of the healing art is thrown wide open to one and all. Therefore you will see that our Woman's Auxiliary * * * has before it this summer and fall the greatest fight and noblest work we have yet undertaken."

VIRGINIA

"Regular meetings with splendid educational programs have been held in all auxiliaries. Special attention has been given to the health programs which have been planned for lay organizations. The Norfolk County Auxiliary has endorsed the health education program of the State Superintendent of Schools. This auxiliary has particularly emphasized yearly physical examinations and proper diet, by showing moving pictures combined with lectures on these subjects before ten schools and civic organizations."



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Literature on request.

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Wisconsin

"Our Public Relations work has followed the recommendations of the National Public Relations Committee as closely as possible. Over one hundred and twenty medical speakers were placed by auxiliary members before lay organizations since May, 1933. Six county auxiliaries have the use of radio stations for health programs. A fifteen minute radio talk on some health subject is given each week by the Executive Secretary of the State Auxiliary. A recently organized auxiliary held an open meeting at which Dr. Cramp of the American Medical Association was the speaker. Hand bills concerning this lecture were printed and distributed by the school children with the result that over seven hundred attended this coming year."

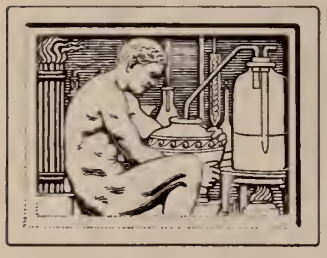
ADVERTISERS' NOTES

Karo Syrup

In this issue of the Journal appears a new advertisement—that of the Corn Products Refining Company, manufacturers of Karo Syrup.

Attention is called to the fact that Karo Syrup is sold in grocery stores even in country districts. Therefore, it can be obtained more readily than other dextro-maltose products which are sold through drug stores alone. The ease with which Karo Syrup or the powdered form can be obtained, as well as its low price, will appeal to physicians everywhere.

New Lilly Research Laboratories Open



Because of the great progress in various subdivisions of several branches of medical science, research has been a field of growing importance in the last quarter century. The scope of research has been particularly broad in the pharmaceutical and biological industry for the reason that it quite naturally divides into three avenues; pure research, production research, and clinical research. Pure research and production research may be said to differ only in their objectives. Pure research becomes a subject for production research as soon as there is a clinical objective. The objective attained, there arises a need for a clinical background.

Among the leading manufacturers of thera-

Southern Medical Association — IN the South, OF the South, FOR the South



28th Annual MEETING

November 13-16, 1934

THE OUTSTANDING MEDICAL meeting of the year in the South, yes, in this Country—the annual meeting of the Southern Medical Association in San Antonio in mid November. In the eight general clinical sessions, the sixteen sections, the eight independent medical societies meeting conjointly, and the scientific and technical exhibits every phase of medicine and surgery will be covered—the last word in modern, practical, scientific medicine and surgery. Addresses and papers by distinguished clinicians not only from the South, but from all over the United States, as well as from Mexico, France and England.

Regardless of what any physician may be interested in, regardless of how general or how limited be his interest, there will be at San Antonio a program to challenge that interest and make it worth while for him to attend.

EVERY PHYSICIAN IN THE SOUTH who is a member of his state and county medical societies can be and should be a member of the Southern Medical Association. The annual dues of $4.00 include the Association's own Journal each month, the Southern Medical Journal — the equal of any, better than many. Southern Medical Association, Empire Building, Birmingham, Alabama.

The SMA ROUND-UP, San Antonio, November 13-16

One of a series of advertisements prepared and published by PARKE, DAVIS & CO. in behalf of the medical profession. This "See Your Doctor" campaign is running in the *Saturday Evening Post* and other leading magazines.

YOU DON'T BELIEVE IN DOCTORS?

"I'm too busy to go to the doctor. And I haven't much faith in doctors anyway."

Every once in a while you hear a person make such a statement—perhaps you have yourself. Does it make sense? Let's see—let's look at life as it used to be and life as it is today . . .

A little over a century ago, smallpox was the rule rather than the rarity—in fact, a case is recorded in which a criminal was identified by the fact that his skin was unblemished by pock-marks!

Today, thanks to vaccination, smallpox has almost completely disappeared. A doctor discovered vaccination—every doctor now offers its protection.



Up until the middle of the 19th Century, a surgical operation was a horrible ordeal. The comforting oblivion of anesthesia was not known, and the lack of proper antiseptics made even the simplest operation an unequal gamble with death.



Today, surgery is so efficient, so advanced, so much a part of nearly everyone's experience, that we take even downright miracles as a matter of course.

Twelve years ago, diabetes was a virtual sentence to death. *Today, doctors can give most diabetics a normal span of life.* Just a few years ago, pernicious anemia was hopeless. *Today, it can be fully controlled.*

Kidney disorders, childbirth, asthma, goiter—the terror of all of them has been lessened by miracles that modern medical science has wrought.

The discovery and application of vitamins have almost eliminated rickets and scurvy . . . and deserve much of the credit for the sturdy legs and healthy bodies of our children. Yet at the beginning of this Century, the word "vitamin" wasn't even in the dictionary.



Many diseases that were shrouded in mystery even as late as 30 years ago, are an open book to the doctor of today. Syphilis, whooping cough, scarlet fever—the causes of all have been discovered since 1900. And that means in most instances, also a method of control.

Medicine is a living thing, constantly growing, constantly developing, constantly moving forward. And the one person who can place this knowledge at your disposal is *your doctor.*

The men and women that comprise the medical profession spend years of preparation in learning to become doctors . . . and they keep in touch with medical progress through clinics, hospitals, medical societies, medical journals, medical conventions, and other agencies which help disseminate this precious knowledge.



It is a sensible thing to call upon your doctor frequently enough to *preserve* health as well as to *restore* health. Faith in your doctor, and intelligent recourse to the knowledge he offers, might mean the difference between a bed of pain and continued good health—between a premature death, and a pleasant and useful "threescore and ten."

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peutic agents who have devoted much attention to research in various divisions of medical science, are Eli Lilly and Company, who, on October 11th, formally opened their new Research Laboratories at Indianapolis. These new laboratories are said to represent three years of study and careful planning in order that the facilities might be adequate to the demands made upon them in an era that is marked by constant change and improvement. The main building is 220 feet long and 53 feet deep. Three stories and a basement provide space for the offices of the research group and for laboratories containing equipment of the latest design for research in the field of chemistry, physiology, pharmacology, and biology, related to medical science. A four-story and basement wing extending back of the main building is 84 feet long and 53 feet wide. This unit or wing is occupied by animal quarters which are supplied with fresh air, cooled and filtered. Temperature control for animals is recognized as essential to accuracy in physiological testing.

Scientific leaders from all parts of the country attended the formal opening of this latest addition to the Lilly laboratories.

The principal speakers at the dedication ceremonies were Sir Henry Dale, C.B.E., M.D., F.R.S., Chairman of the National Institute for Medical Research, London, England, and Secretary of the Royal Society of London; Sir Frederick Banting, of the University of Toronto; and Dr. Irving Langmuir, Director of Research for the General Electric Company. Other notables who took part in the dedication exercises were Dr. Elliott P. Joslin, Dr. Frank R. Lilly, Dr. Charles R. Stockard, Dr. George H. Whipple, and Dr. Carl Voegtlin. Following the afternoon program the new laboratories were open for inspection.

Treatment of Varicose Veins

Dr. T. Henry Treves-Barber in his book, "The Treatment of Varicose Veins of the Lower Extremities by Injections," states that remarkable achievements have been made within the last few years for the cure of varicose veins and their complications. No other branch of surgery can claim to have acquired, in such a short space of time, more satisfactory or more brilliant results than the sclerosing method for the obliteration of varicosed veins. It is indeed surprising that a complex, disabling, dangerous and, hitherto, an almost incurable surgical disease has now become, on the whole, one of the easiest to cure. All the



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Advertisers in our Journal bear the stamp of approval of the American Medical Association and also of the Florida Medical Association. They are worthy of the patronage of our members.



THE solids of milk are precipitated in a few minutes after ingestion. Actually, it is one of the most solid of foods. Why, therefore, satiate an unwilling appetite with the seven-eighths of milk that is water?

KLIM, powdered whole milk, contains in one ounce the caloric value of a full 8 ounce glass of milk. And, besides its minimum bulk, KLIM's soft, friable curd makes it doubly valuable in any difficult feeding case.

Below is a recipe from the KLIM cookbook (Reinforced Diet Recipes), using the concentrated butterfat, mineral, lactose, protein and vitamin content of KLIM. Write for as many of these practical helpful booklets as you may need for patient distribution. You will also receive samples of KLIM.



A Typical Recipe from "*Reinforced Diet Recipes*"

MASHED POTATOES

Potatoes to make 2 cups when mashed
2 tablespoons butter
½ cup hot water
1 teaspoon salt
¼ teaspoon pepper
5 teaspoons KLIM

To mash potatoes add the butter and the hot water. Beat until butter is melted. Add salt and pepper. Then add the KLIM a tablespoon at a time. Beat until fluffy.
Volume: 2¼ cups.

This recipe furnishes ⅞ cup of milk (154 calories) over normal recipes.

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old-time palliative measures such as bandages, elastic stockings, numerous dressings for ulcers, ointments, etc., may now be, in the vast majority of cases, considered as things of the past and of historical interest only.

The National Drug Co., Philadelphia, will be very glad to forward literature on Moru-quin (Solution of Sodium Morrhuate, Alkaloidal Quinine and Benzyl Alcohol) on request.

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Clinical tests prove conclusively that pregnancy is a drain upon the woman's calcium reserve. Very often this is manifested by softening of the bony structure . . . including the teeth. It is a well-known fact that pregnant women very often have decaying teeth, and even lose their teeth during pregnancy.

Such women need their calcium intake increased—and their ability to mobilize calcium augmented. For the drain upon calcium is so great at times as to actually abstract calcium from their bones and teeth.

Cocomalt because of its admixture of milk supplies an abundant amount of calcium and at the same time a sufficient amount of Vitamin D to help mobilize the calcium. Cocomalt is licensed by the Wisconsin University Alumni Research Foundation under Steenbock Patent No. 1,680,-818. One glass or cup of Cocomalt, prepared as directed, contains not less than 30 Steenbock (81 U.S.P. revised) units of Vitamin D. It is accepted by the Committee on Foods of the American Medical Association.

Medical Men For Things Medical

"The principle that medical men should be the ones to exercise control over medical service is almost axiomatic. Yet there is confusion of thought where there could be straight thinking if all the facts were brought out and faced.

"There are those who would virtually make the physician an employee of the state. They fail to recognize the utter incompatibility between the American political system and the methods of truly professional men.

"There are those who complain about the scarcity of physicians. Yet it is a fact that while England has one doctor for 1,490 persons, France one for 1,690, and Sweden one for 2,890, there is in the United States one physician for every 780 persons.

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Early entrance advisable.



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NERVOUS AND MENTAL

A modern neuropsychiatric hospital with special laboratory facilities for the study and treatment of early cases. Also a department for the treatment of drug and alcoholic addictions.

The Sanitarium is located on the Marietta Electric Car Line, ten miles from the center of Atlanta, near Smyrna, Ga. The grounds comprise 80 acres. The buildings are steam heated, electrically lighted, and many rooms have private baths.

Address communications to Brawner's Sanitarium, Smyrna, Ga., or to the city office, 478 Peachtree St., Atlanta, Ga.

DR. JAS. N. BRAWNER, Medical Director.
DR. ALBERT F. BRAWNER, Resident Physician.

"There are those who denounce our hospitals on the score of high charges for service, but the truth is that the cost per day of a hospital room with meals and the day and night personal ministrations required by an invalid is usually less than a well person would pay for mere room and meals in a first-class hotel.

"There are those who would like to let down the bars to self-medication. Yet the fact is that during the last few generations the average span of human life has been extended ten years, chiefly through the discoveries of medical science.

"Physicians know these things. They spend years acquiring an education on the care and repair of the most marvelous mechanism on earth—the human body. But they would readily admit that this education does not qualify them for telling railroad executives how to solve transportation problems or impressarios how to stage an opera. The work of the world needs many kinds of specialized knowledge, but certain it is that each field of work will be best managed by those who know it best."—from Mead Johnson & Company's announcement in Hygeia, August, 1934.

Quinine Formulary, 26 Pages, 58 Prescription Formulas, Merck & Co., Inc., Rahway, N. J.

Informative and refreshing is the Merck booklet entitled "Quinine Formulary." The authoritative information on the therapeutic application of quinine which it contains should prove invaluable to the physician. Thirty-eight conditions in which quinine is therapeutically effective, including malaria, with illustrative prescriptions occupy the body of the text. The use of quinidine, the cinchona alkaloid of recognized value in auricular fibrillation, quinine and urea hydrochloride as a local anesthetic, the tonic use of quinine, and its employment for aborting the "common cold" are presented in prescription form. Included are a list of cinchona alkaloids and their sales available under the Merck label, a table of solubilities, and a bibliography of thirty authoritative references.

The pioneer history of quinine and Merck, dating back to two years after quinine had been isolated from cinchona bark by Pelletier & Caventou, and the fact that today Merck & Co., Inc., are the largest makers of quinine in this country, lend additional interest to this unique and useful publication.



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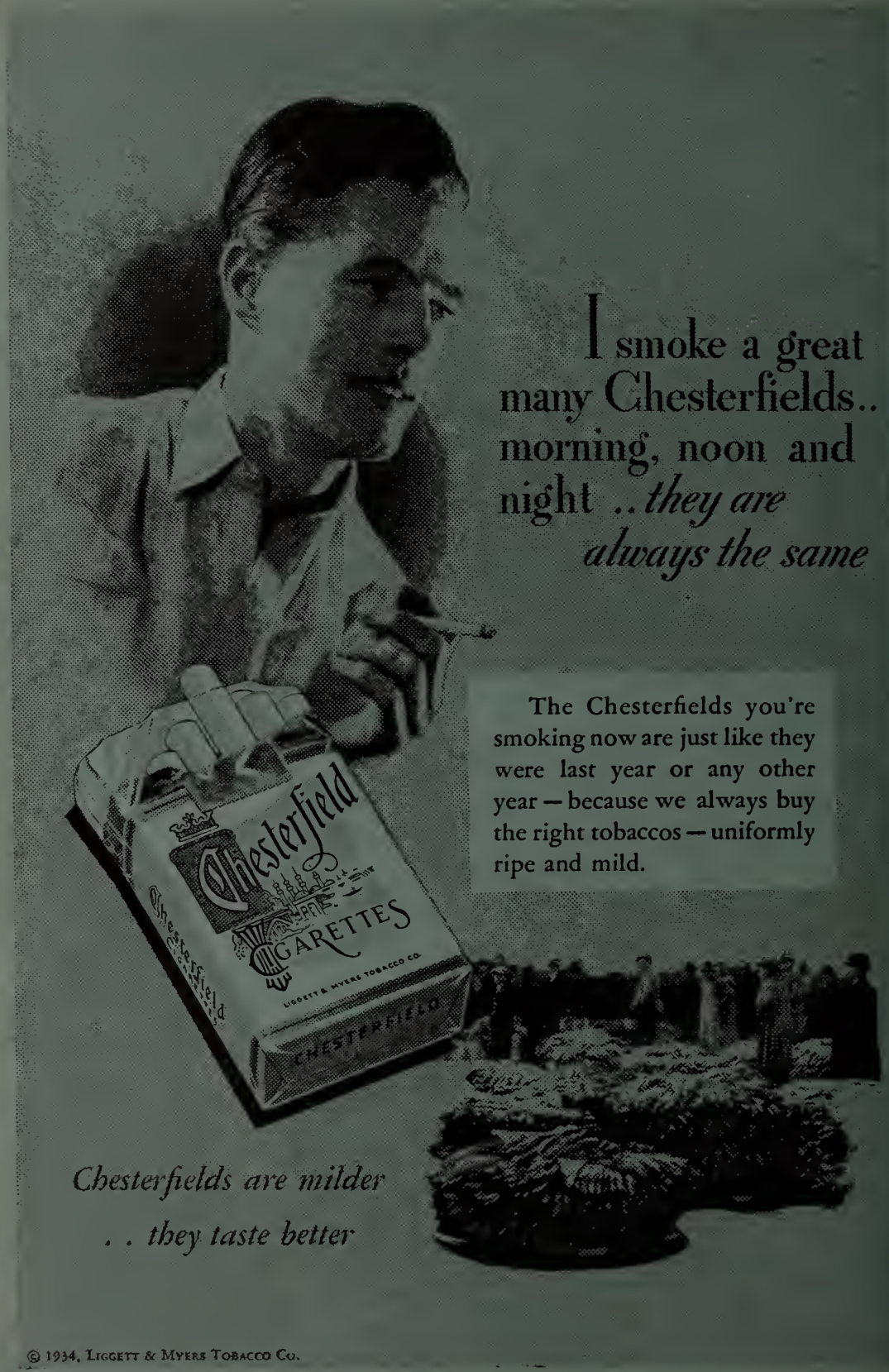
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		Date	Time	Place	Luncheon?	
Alachua	Harry M. Merchant, M.D., Gainesville.	2nd Tuesday	12:00 Noon	White House Gainesville	Yes.	90%
Bay	Allen H. Miller, M.D., Millville.					71%
Brevard	L. K. Hicks, M.D., Melbourne.	2nd Tuesday		Varies	Yes.	67%
Broward	O. C. Brown, M.D., Ft. Lauderdale.	Last Wednesday.	8:00 P.M.	Elks' Hall Ft. Lauderdale	No.	94%
Columbia	T. H. Bates, M.D., Lake City.	1st Monday	7:30 P.M.	Blanche Hotel Lake City		100%
Dade	Robert T. Spicer, M.D., Miami.	1st Friday	8:30 P.M.	Club Room Huntington Bldg. Miami	Occasionally.	95%
DeSoto-Hardee-Highlands	L. W. Martin, M.D., Sebring.	2nd Tuesday	8:00 P.M.	Varies	Yes.	93%
Duval	B. F. Woolsey, M.D., Jacksonville.	1st Tuesday	8:15 P.M.	Mayflower Hotel Jacksonville	No.	83%
Escambia	J. M. Hoffman, M.D., Pensacola.	2nd Tuesday	8:00 P.M.	Board of Health Building Pensacola	No.	76%
Hillsboro	John S. Helms, Jr., M.D., Tampa.	1st Tuesday	8:00 P.M.	Tampa Municipal Hospital Tampa	No.	100%
Jackson	Lewis Pierce, M.D., Marianna.	2nd Tuesday	7:30 P.M.	Hotel Chipola, Marianna	Yes.	91%
Lake	W. L. Ashton, M.D., Umatilla.	1st Thursday	12:30 P.M.	Eustis	Yes.	94%
Lee	Robley D. Newton, M.D., Ft. Myers.	3rd Friday	7:30 P.M.	Lee Memorial Hospital Ft. Myers	No.	100%
Leon-Gadsden-Liberty-Wakulla-Jefferson	O. G. Kendrick, M.D., Tallahassee.	Quarterly	3:00 P.M.	Varies	Yes.	100%
Madison	Geo. O. Davis, M.D., Madison.					100%
Manatee	W. D. Sugg, M.D., Bradenton.	3rd Tuesday	7:00 P.M.	Whitfield Country Club Bradenton	Yes.	100%
Marion	Richard C. Cumming, M.D., Ocala.	3rd Thursday	12:30 P.M.	Marion Hotel Ocala	Yes.	100%
Monroe	W. R. Warren, M.D., Key West.	1st Sunday	9:00 P.M.	Varies	Yes.	100%
Orange	John A. Pines, M.D., Orlando.	3rd Wednesday	8:30 P.M.	Varies	No.	100%
Palm Beach	R. Henry Baldwin, M.D., W. Palm Beach.	4th Monday	8:00 P.M.	Good Samaritan Hospital W. Palm Beach	No.	100%
Pasco-Hernando-Citrus	Geo. R. Creekmore, M.D., Brooksville.	2nd Thursday	7:00 P.M.	Varies	Yes.	100%
Pinellas	O. O. Feaster, M.D., St. Petersburg	1st Friday	8:00 P.M.	Assembly Room, 5th floor, P. & L. Bldg. St. Petersburg	No.	100%
Polk	J. R. Boulware, Jr., M.D., Lakeland.	2nd Wednesday in Feb., Apr., June, Aug., Oct., Dec.	1:00 P.M.	Lakeland	Yes.	98%
Putnam	E. W. Warren, M.D., Palatka.	2nd Thursday	7:00 P.M.	James Hotel, Palatka	Yes.	100%
St. Johns	Reddin Britt, M.D., St. Augustine.	3rd Tuesday	8:30 P.M.	Varies	Yes.	100%
St. Lucie-Okeechobee-Indian River-Martin	J. D. Parker, M.D., Stuart.	3rd Thursday	8:00 P.M.	Varies	Yes.	100%
Sarasota	J. E. Harris, M.D., Sarasota.	2nd Tuesday	8:30 P.M.	Varies	Occasionally.	100%
Seminole	J. T. Denton, M.D., Sanford.	2nd Monday	7:00 P.M.	City Hospital Sanford	Yes.	100%
Sumter	W. E. Mitchell, M.D., Coleman.	2nd Tuesday		Varies	No.	100%
Taylor	C. A. O'Quinn, M.D., Perry.	Last Friday	8:00 P.M.	Dixie-Taylor Hotel Perry	Yes.	100%
Volusia	Joseph H. Rutter, M.D., Daytona Beach.	2nd Tuesday	7:30 P.M.	Varies	Yes.	94%
Walton-Okaloosa	A. G. Williams, M.D., Lakewood.	3rd Thursday	8:00 P.M.	Varies	Occasionally.	100%

NOTE—Secretaries: Please submit information to complete the above schedule.



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NEXT SESSIONS Florida Medical Association, Ocala, May 13, 14, 15, 1935.
Southern Medical Association, San Antonio, November 13-16, 1934.
American Medical Association, Atlantic City, June 10-14, 1935.

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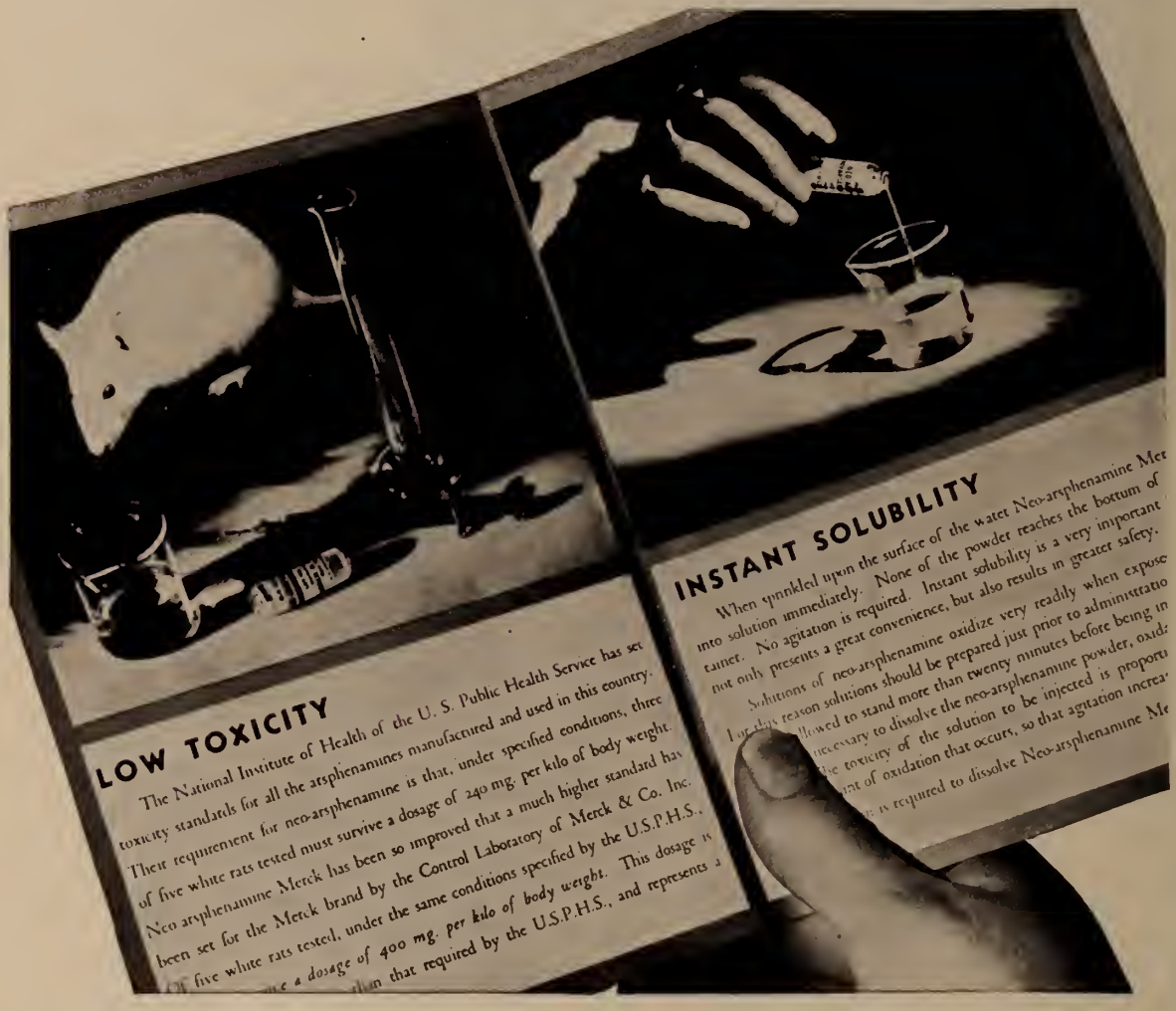
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PUBLISHED MONTHLY

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SURGICAL TREATMENT OF PULMONARY TUBERCULOSIS*

KENNETH A. MORRIS, M.D.,
Jacksonville.

(From the Department of Thoracic Surgery, Duval County Hospital. Chest Team: Internist, Louie Limbaugh, M.D.; Roentgenologist, W. M. Shaw, M.D.; Surgery, J. Knox Simpson, M.D., and Kenneth A. Morris, M.D.)

The surgical treatment of pulmonary tuberculosis is based on the principles of rest and compression of the lungs; rest from the constant respiratory movements and the compression of tuberculous cavities. Slow to spread at first, this form of therapy has earned a permanent and well-deserved place in the treatment of pulmonary tuberculosis. It is true that for the past four or five years, in some medical centers, there has been too much enthusiasm for surgical or collapse therapy. That such waves of enthusiasm bring about too frequent and unwarranted applications of a valuable method of treatment, the writer is aware. The purpose of this paper is to give a conservative discussion of the principal methods of mechanical or collapse therapy.

It should be borne in mind that tuberculosis is primarily a constitutional disease with local manifestations. Dettweiler was the first to advocate rest in bed and in the great majority of cases this constitutes sufficient treatment. The old formula of rest, fresh air and good food still holds good.

Many patients, however, who do not improve with conservative treatment may be greatly benefited by some form of collapse therapy. It is not wise to wait too long before instituting treatment in patients with active pulmonary tuberculosis with or without cavities who do not show improvement or who show signs of retrogression under conservative treatment. Bronfin believes that the following axioms may be safety followed. "A patient between the ages of 15 and 50, not in the terminal stages of the disease and free from grave tuberculosis or non-tuberculosis complications, who fails to improve in six months under a properly conducted rest regime should be considered as a possible suitable subject for collapse therapy. Serious symptoms, such as recurring hemoptysis, or physical and roentgen evidence of beginning cavitation, justify resorting to collapse measures at an earlier date." Artificial pneumothorax should always be tried before resorting to more radical procedures. The value of this method is well recognized and it alone may bring about economic recovery in about forty per cent of cases.

The surgical treatment of tuberculosis in this city has practically been confined to the Duval County Hospital. Diseases of the chest present difficult problems. To avoid mistakes all cases have been reviewed by a chest team composed of the internist, roentgenologist and surgeon. There are three principal methods of collapse therapy: (1) artificial pneumothorax, (2) phrenic exerisis, (3) thorocoplasty. Our chest team has considered artificial pneumothorax strictly a medical procedure.

PHRENIC EXERISIS

The simplest and safest surgical procedure is phrenic exerisis or evulsion of the phrenic nerve. The phrenic nerve springs chiefly from the fourth cervical, but usually receives branches from the third and fifth cervical and one from the sympathetic. Its roots unite about one to two inches above the clavicle and from this point the nerve passes downward and medialward on the anterior scalenus muscle. Under local anesthesia it can easily be exposed through a short incision along the external border of the sterno mastoid muscle. Simple cutting of the nerve was first proposed by Stuertz in 1911 but it was found that a section alone did not always completely paralyze the diaphragm. Sometimes fibers from the sixth and seventh cervical and the nerve to the subclavious muscle joins the main trunk below the site of simple phenicotomy. For this reason the operation of phrenic exerisis or evulsion of the nerve by pulling up from 2 to 12 inches of the distal portion is necessary to obtain complete paralysis. Phrenic exerisis paralyzes the diaphragm and is equivalent to the introduction of about 300 to 400 cc. of air in the pleural cavity and brings about a diminution of one-third to one-fourth

*Read before the Sixty-first Annual Meeting of the Florida Medical Association, Jacksonville, April 30, May 1 and 2, 1934.

lung volume by allowing the diaphragm to rise one to three inches.

The indications for phrenic exerisis are:

(1) The first phrenicotomy by Stuertz was used as a curative measure for chronic, unilateral, lower lobe tuberculosis.

(2) Cases in which pneumothorax is indicated but cannot be induced because of adhesions to the lung.

(3) As a test for the patient's ability to stand thorocoplasty but chiefly to improve the patient's general condition and make him a safer operative risk.

(4) To control profuse or recurring hemoptysis when pneumothorax cannot be induced.

(5) As an adjunct to pneumothorax by reducing the residual cavity and lengthening the interval between fills. Phrenic exerisis also relaxes adhesions which prevent effective collapse.

(6) To control excessive cough and expectoration in bilateral lesions with only limited cavitation in the better lung. It brings about ease of expectoration and often considerable general improvement.

Thorocoplasty

Extra-pleural thorocoplasty as standardized by Sauberbruch consists in the extra-pleural reaction of the posterior portion of the upper ten or eleven ribs. From two centimeters of the first rib to ten and eleven centimeters of the tenth and eleventh rib are removed. The pleural cavity is not opened. The posterior portion of the ribs is fixed and forms the greatest part of the transverse diameter of the chest. When this part is removed the movable anterior portion readily collapses and the greatest amount of compression is obtained. Rest of the lung and compression of its cavities are usually absolute and permanent. Ethylene is the anesthesia of choice and the operation is safer when performed in two or three stages.

Generally speaking, thorocoplasty is indicated in the following conditions:

(1) Unilateral fibro-ulcerative pulmonary tuberculosis where the other lung is healthy or healed and where no improvement can be shown under sanitarium treatment or simple methods of collapse therapy.

(2) Large unilateral cavities which do not respond to simple methods may be effectively collapsed by thorocoplasty.

(3) Tuberculous empyema when there is no tendency of the lung to expand following frequent aspirations. It is a known fact that without surgical treatment the prognosis for these patients is grave.

However, the problem is not so simple. The close cooperation of the internist, roentgenologist and surgeon is essential. The resistance of the patient as evidenced by scar tissue is the most important consideration. Fibrosis with cavitation where there is shrinking and fixation of the lung present the ideal condition for permanent collapse. Archibald used a rough working rule and does not operate if the trachea is in the mid line. Other factors such as persistent bacilli in the sputum, hemorrhage, flare ups, danger of spread to the other lung and chronic cases where there are signs of slipping should of course be considered. But one should ask the question: "What will become of the patient if no operation is attempted?" The internist who has a good perspective of the patient's whole clinical course and knows the patient's level of resistance can best answer this question.

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DISCUSSION

Dr. W. M. Shaw, Jacksonville:

Gentlemen, it has been quite a pleasure to work with this chest team, and the work that I am going to show you is Dr. Morris' work, and not the x-ray department's.

(Films)

These two films represent two taken from the examination of a patient over a period of five and one-half years with an extensive lesion in the lower left chest. (Figs. 1 and 2.) Pneumothorax was attempted, but unsuccessful because of adhesions. Phrenic exerisis was done early in the case. The patient has shown a slow but very satisfactory improvement. We examined her seven times during this period of five and one-half years. We now consider her an arrested case; she has been discharged from the hospital and is doing light work at home. She walked into the hospital about ten days ago for this film.



Fig. 1. Case 1. Ill 2 years. Disease limited to the right side. Pneumothorax unsuccessful because of pleural adhesions.

You see the lesion in this side. This film was made just after the operation on the phrenic nerve on the left side which left the diaphragm as you see. The patient was put on rest and nothing else after this operation a little over a year ago and you see the return of this lung to an almost normal condition. The diaphragm of course will always be high.

The next case is one of thorocoplasty. (Figs. 3 and 4.) The patient has been sick five years with bilateral disease—very ill. She had prolonged bed rest with some improvement during the past year. A phrenic exerisis was done as a preliminary to thorocoplasty several months later. Thorocoplasty was done within the past three months. There has been a great improvement in the clinical picture and the well being of the patient. This film represents the condition before thorocoplasty with a large cavity in this area, and disease here. The patient had been in bed about five and one-half years when that was made. Thorocoplasty was done about three months ago



Fig. 2. Case 1, after phrenic exerisis. Phrenic exerisis year ago. Improvement satisfactory with no cough, no elevation of temperature. Patient has gained weight and is up and about. No elevation of right diaphragm.



Fig. 3. Case 2. Ill 5 years. Bilateral disease. Some improvement in right lung with prolonged rest. Phrenic exerisis preliminary to thorocoplasty. Note large cavity in left apex.

by Dr. Morris and you see the result. The cavity has come down to this size. It has only been from sixty to ninety days, but the patient has shown considerable improvement. By using support to the shoulders and with her clothes on it is hard to tell that she has had this mutilating operation. This is a case of thorocoplasty and phrenic exerisis.

The third and last case represents a patient ill four and one half years. (Figs. 5 and 6.) Pneumothorax was considered, but adhesions prevented compression of the lung. A very large cavity developed in the left upper. The right lung healed under rest. Thorocoplasty on the left side was done about one year ago. The cavity has been greatly reduced. There is no elevation in temperature at this time. Patient has gained considerable weight and is still improving. I am only going to show two films. We examined this patient about nine times. This film represents the large cavity. This lung cleared up to a marked extent. But this cavity resisted and grew larger. (Demonstrating with pointer.) The cavity grew larger and larger. We could not get the lung com-



Fig. 4. Case 2. Thorocoplasty in 2 stages. Feb., 1934. First improvement shown following thorocoplasty. Large cavity not yet completely collapsed. Third stage operation probably necessary.



Fig. 5. Case 3. Ill 4½ years. Pneumothorax prevented by adhesions. Very large cavity left lung.

pressed because we could not get air in between the lung and chest due to the adhesions. Thorocoplasty was done in two stages, the first five ribs the first time, and the lower five at the second operation. You can see the compression of the chest wall. This patient is still improving, has normal temperature and no cough.

I think these cases are the only ones we will have time to demonstrate.

Dr. Louie Limbaugh, Jacksonville:

The use of surgical procedures in the treatment of pulmonary tuberculosis has increased markedly in the past few years. Thorocoplasty was very rarely done until recently. Even artificial pneumothorax therapy is now very much more commonly used. The indications for such therapy are now realized to be more liberal than was formerly thought. Surgical measures are instituted earlier in the treatment and not, as previously, only after years of unsatisfactory rest cure had passed.

It is accepted that disease in the contra-lateral lung is not necessarily a contra-indication to some form of surgical treatment of the more advanced lesion. Tuberculosis lesions may become arrested



Fig. 6. Case 3. Thorocoplasty one year ago. Cavity greatly decreased. No elevation of temperature and no cough at this time. Patient has gained considerable weight and is still improving.

in one lung while the other lung is collapsed by artificial pneumothorax, phrenic-exerisis or thorocoplasty.

The cases presented by Dr. Morris are from the Duval County Hospital. None of us is primarily interested in tuberculosis, but the work has gradually built up in that institution which has beds assigned to tuberculosis cases. A great deal of credit is due the Surgical Staff for their cooperation and interest in this type of surgery.

Perhaps the frequent use of surgical measures can be illustrated by a reference to the white patients in the County Hospital. Today there are nineteen white patients in the tuberculosis wards. Of these, nine are on artificial pneumothorax therapy, five have had phrenic nerve operations and two have had thorocoplasties.

I wish to stress the point that patients taking the rest cure in their homes should be given the opportunity of careful consideration of some form of surgical therapy which might be feasible and which perhaps would hasten their recovery if not actually save them from a fatal progression of the disease.

INTESTINAL OBSTRUCTION, A STATISTICAL STUDY*

Joseph S. Stewart, Jr., M.D.,
Miami.

This report is based on a study of all cases of mechanical intestinal obstruction occurring at the Jackson Memorial Hospital (Municipal) for a three-year period: March, 1930, to June, 1933. Paralytic obstruction is not included.

There was a total of 83 cases, 49 of obstruction (other than hernia), and 34 of strangulated hernia. The combined mortality rate was 44.4%; for obstruction (other than hernia) 49%; and for strangulated hernia 38%.

TABLE 1.

Mortality in Obstruction (other than hernia) and in Strangulated Hernia.

	Number of Cases	Deaths	Mortality
Total Cases	83	37	44.4%
Obstruction (other than hernia)	49	24	49%
Strangulated hernia	34	13	38%

*Read before the Sixty-first Annual Meeting of the Florida Medical Association, Jacksonville, April 30, May 1 and 2, 1934.

TABLE 2.

Age Incidence

Ages	Obstruction (other than hernia) No. of Cases	Strangulated Hernia No. of Cases
80 - 90	0	1
70 - 80	1	9 = 46%
60 - 70	8	7
50 - 60	4	3
40 - 50	7 = 47%	2
30 - 40	10	4
20 - 30	3	3
10 - 20	3	3
Average Age	36	51

Note: In Strangulated Hernia 46% occurred in the age group 60 to 80.

Strangulated hernia gave a mortality of 11% less than obstruction, though the age incidence was fifteen years greater. This is probably due to the greater ease of diagnosis in strangulated hernia and the better education of both laity and profession as to the need for immediate surgery.

TABLE 3.

Hour of Illness Operated

		Average hour of illness operated	Average hour in hospital before operation
Obstruction (other than hernia)	Staff and Private	92	23
	Staff	101	
	Private	73	
Strangulated hernia	Staff and Private	38	7
	Staff	49	
	Private	24	

Table 3 shows clearly one of the reasons and the main reason for the terrific mortality. An average of 92 hours elapsing between the first symptom and operation; and 23 hours from hospital admission to operation. Though the surgeon, particularly in staff patients, may have no control over the 92-hour period, he certainly can control the additional 23-hour wait after hospitalization. Surely preparation for operation, even with administration of large amounts of saline, should be reduced to one or two hours. The Massachusetts General Hospital series shows a mortality of 17% when operation occurs in the first twenty-four hours; 35% in forty-eight hours and 60% after forty-eight hours. And Moynihan[2] says: "Anything over a 10% mortality is the mortality of delay." It is difficult to offer an explanation for the 38-hour average wait in strangulated hernia or even more for the 24-hour wait in the private patients of this group. The patient may be partly responsible but I cannot

help but feel that the greatest responsibility lies with the attending physician. I am indeed sorry that the records in this series would not divulge the time elapsing between the first visit of the attending physician and surgical relief. This table gives us in clear-cut staccato tones, the clew that our best hope lies in earlier diagnosis and earlier surgery; that fecal vomiting is not a symptom of obstruction but rather a sign of approaching death.

TABLE 4.
STAFF AND PRIVATE PATIENTS MORTALITY RATE

	Obstruction (other than hernia)	Strangulated Hernia
Private	30%	38.85%
Staff	61.18%	37.5%

Table 4 shows the interesting equal mortality between staff and private patients in strangulated hernia with the remarkable difference of 61% to 30% in obstruction (other than hernia). A large proportion of staff patients in this hospital are colored and it is a well-known fact that they come in for relief from obstruction at times varying from three days to two weeks after the initial symptoms. They are lulled into a sense of well-being by the cessation of the early pain and finally in the last few hours of ebbing life, they are brought in by their relatives in a condition far beyond any hope of aid. I see no hope of materially reducing the mortality figure of 61% in this group.

Table 5 shows the average white blood count and its only value, to my mind, is to show that the leukocyte count is of practically no value as an aid in diagnosis for it is only in the late or neglected cases that it rises high.

TABLE 5.
WHITE BLOOD COUNT

	Obstruction (other than hernia)	Strangulated hernia
Average	14,291	11,333
Smallest	2,800 (died)	6,600
Largest	40,000 (recovered)	14,300

Table 6 shows the terrific mortality of 80% where resection is found necessary. A voice from the dead appealing to us for earlier surgery and perhaps for exteriorization rather than resection.

TABLE 6.
MORTALITY AFTER RESECTION

No. of cases resected	Deaths	Mortality
5	4	80%

From Table 7 we learn that 56% of the cases of obstruction (other than hernia) follow and result from previous abdominal surgery. A hint to all that in the presence of an abdominal operative scar, think not lightly of abdominal pain, however mild or atypical it may be. I am sorry the records in this study do not give the incidence of drainage in the primary operation for this information would have been of great value and I believe would have opened our eyes to the unfortunate end results of adherence to the hackneyed quotation: "When in doubt drain."

TABLE 7.
PERCENTAGE OF POSTOPERATIVE OBSTRUCTION

Patients having previous abdominal surgery and obstruction caused as a result thereof:	27 = 56%
Patients having no previous abdominal surgery:	17 = 34%
Not stated:	5 = 10%

Note: Fifty-six per cent, over half, of the obstruction cases are post-operative, from two days to many years.

Table 8 shows the part of intestine involved (when stated on records) and the incidence of intussusception.

TABLE 8.
PART OF INTESTINE INVOLVED
(if stated on chart)

Sigmoid	1	Ileum	24	Caecum	2
Colon	5	Jejenum	1		

Intussusceptions: 2 cases = 2.4%. Mortality 50%.

During the course of this study, I was rather amazed at the great variation in operative procedure employed by the different operators (23 different operators). And yet, when we consider the varying opinions expressed in the literature today it is hardly surprising! I feel sure that earlier diagnosis and earlier surgery will reduce the mortality rate considerably but I feel just as strongly that there is need for improvement in the average operative procedure. The impression gleaned from these records is that perhaps the most common error is the tendency to do too much; too great an urge to remove the obstruction regardless of its cause, rather than to employ the simpler measure of enterostomy until the patient's condition will allow a more formidable operation. There was a noticeable scarcity of enterostomies done by the Mayo modification of the Witzel method. I feel that when this method is more generally appreciated there will be less hesitancy in performing enterostomy, since the fear of fistula is practically eliminated.

The diagnosis of partial intestinal obstruction increased the mortality rate in this series. It is a dangerous diagnosis. It may give the physician an optomistic happiness but it carries too many patients to their graves.

In conclusion, may I suggest that to lower the universally high mortality rate in intestinal obstruction a more thorough study of, and understanding of, the physiological and pathological principles involved are necessary—first for the practitioner, that he may more easily and rapidly diagnose the protean manifestations of this puzzling catastrophe, and second for the surgeon, that he may more readily and efficiently apply his art to the various pathological problems presented.

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DISCUSSION

Dr. Walter Jones, Miami:

I feel that the subject which Dr. Stewart has brought to your attention is one upon which we could well spend considerable time. When we view the high degree of mortality with which we are confronted in the more up-to-date hospitals of our State we are astounded.

It is self-evident from the statistics that have been reported that a great percentage of the mortality is due to delay. Therefore early diagnosis and early treatment are the only means by which we can reduce this mortality rate. The early treatment of intestinal obstruction demands the attention of every surgeon, but the surgeon is helpless unless he can receive cooperation from the man who is seeing the case first hand. The surgeon may be able to render a most admirable piece of surgery at the time the case is seen, but it is impossible to accomplish anything unless he has been able to see that case sufficiently early to be of value.

When the question of intestinal obstruction arises, when perhaps there has been pain with small amount of vomiting, not necessarily distention and not necessarily fecal vomiting (then we have waited too late), I can see no reason why we cannot do a simple introduction of a nasal tube with automatic suction such as brought forth by a Northwestern Medical Clinic during the past year and presented very admirably in the Journal of the American Medical Association. That, in the adhesive type of obstruction, will perhaps give complete relief. You have done no harm to your patient and perhaps you have helped to lower the high mortality rate you have just seen. If by using this automatic suction you have not accomplished anything—and it will become quite self-evident in a short period of time that you are either getting results or not getting results—then immediate surgery is indicated.

The simplest type of surgery possible should always be used in every case of intestinal obstruction. Even though we see these cases early, I feel we should not attempt at this time to do any more than is absolutely necessary to relieve the obstruction; we should not attempt to do a reparative operation. With simple adhesions, simply clip, close abdomen and send patient back to room. In case of large bowel we meet a condition which is quite different. These cases of partial obstruction in the large bowel I feel are simply matters for temporary relief at the time seen and not cases to be handled for complete operation. In every case of obstruction of the large bowel past the hepatic flexure there should be preliminary drainage before resection or reparative operation is attempted.

In those cases which come to us late and are well past all hope except immediate operation, I feel that perhaps we can help the patient to reach the table in better condition by means of nasal suction tube. At the same time fluid is given by the various methods which we may see fit. Thus we are able to save a lot of these patients from shock. A simple nasal suction will remove some of the toxins which have accumulated in the intestines, and also relieve the gas which has accumulated.

We could talk indefinitely on the subject of intestinal obstruction, and I wish we had more time.

Dr. F. J. Waas, Jacksonville:

Dr. Stewart has asked me to outline a few symptoms which are conspicuous in the diagnosis of intestinal obstruction. The attack is likely to be ushered in by abdominal pain, of a colicy and cramp-like character at the onset, often becoming constant after the first twelve to twenty-four hours; and by vomiting, which becomes more profuse and persistent as the disease progresses, taking on the characteristics of "fecal" vomiting in the late stages. While the lower bowel may be emptied once after the onset of the attack, either voluntarily or by means of enemas, subsequent enemas usually fail to produce either fecal material or gas. Abdominal distension usually develops, although it may be negligible in amount if the obstruction be situated high in the small intestine.

Visible peristalsis may occasionally be seen and in the presence of the symptoms already referred to is characteristic of the disease; but it is not present as commonly as one might suppose, and is rarely seen where strangulation exists. The temperature and pulse rate are usually normal, although not infrequently a subnormal temperature is encountered early in the disease.

A very important diagnostic point that has impressed me in reaching my conclusions in the diagnosis of this condition, where the obstruction is found in the small intestine, is that the pain is usually located more or less on the left side between the upper and lower abdominal quadrant. Whenever a patient complains of pain in the left side, especially as Dr. Stewart brought out, where there is a previous abdominal scar, one must be very apprehensive of the possibility of intestinal obstruction. One of the chief diagnostic adjuncts which has appealed to me recently is the x-ray. Early consultation with the roentgenologist has given me most valuable information in reaching early conclusions in the diagnosis of intestinal obstruction. Usually there is dilatation at the proximal end of the gut with contraction of the distal loop of the gut. I think an examination by the roentgenologist is most important in keeping down the severe mortality which is only going to be overcome by early diagnosis.

Relative to the cause of death in cases of intestinal obstruction, these patients usually die of duodenal dilatation, or duodenal toxemia which makes its impression felt on the chemistry of the blood, giving us a picture of hypo-chloridation or alkalosis; in other words, the patients usually die an alkaline death.

The blood chemistry usually shows a high CO_2 combining power, a lowered blood chlorides, an elevated non-protein nitrogen. About the blood picture in cases of intestinal obstruction: As Dr. Stewart mentioned, it is sometimes of very little information to us. You may not have a marked leukocytosis, but you do have a definite increase in the polys. According to the Schilling classification you usually have a definite shift to the left.

The blood chemistry, the blood picture associated with the symptoms above outlined, and an early consultation with the roentgenologist will give us very valuable information in reaching an early diagnosis of intestinal obstruction, and in that way serve us very markedly in reducing the high mortality of this appalling condition.

THE MENTALLY ILL CITIZEN

His Care, Especially as Applied to Florida*

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Out of a cosmic world of chaos man evolved. Man soon became gregarious and not only separated into races—white, red, yellow and black—but within these races formed groups with similar interests, similar vocations and similar intellects. As civilization developed those who were distraught, anti-social and peculiar, began to be recognized as such. As old as the history of man is the story of the mentally abnormal man. One has only to read the early history of the Egyptians, the Greeks, the Hebrews, the Babylonians to realize this fact.

The word, insane, is of Greek origin and means not sound in mind. The insane have been variously considered by different peoples in separated periods of history. The insane have been considered mad and were killed, as fools and nuisances and were neglected and starved, as being possessed of devils and were feared, as being saints and were worshipped, and as endowed leaders and were followed. And these concepts have pertained even to the present recollection. Today the insane are not infrequently legally killed; in the mountain regions and on isolated shores they are shoved down to become wild men or beach-combers or there are instances in which they have been tied for years in cabins; the insane are at times sought as clairvoyants for good or for evil; and millions follow insane prophets or reformers who heal by faith or institute some religious cult or some form of government.

The desire to do something for the benefit of the insane has been long existent and until recently largely futile. Even with modern psychiatry and modern equipment much is left undone and much, I regret to say, is overdone. The Egyptians began to treat insanity long before the Christian Era. Music was used "to soothe the savage breast" and the patients were shown beautiful sights but, better still, occupational therapy was used. The Greek physicians treated the insane as those suffering from disease and advocated manual labor and even protested against mechanical restraint. But these benign measures disappeared in the Middle Ages during which the prevailing idea became that of de-

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moniacal possession. Physical torture, chains, and dungeons became the therapeutic measures employed for the severe cases while the milder cases were carted or driven around from shrine to shrine in the hope that some saint would drive the devil out. The patient sometimes had a change of delusions, just as he may have in some modern occult procedure, and the shrine gained a shouting advocate to establish its reputation for the miraculous, and the shrine caught more suckers and filled its coffers with coin. People then began to think that witches caused insanity, so, as a preventive measure, the witches were killed. They were usually harmless, demented souls, or enemies to be rid of.

Prisons and monasteries began to be full of the insane but it was not until the fifteenth century that any place took on the semblance of an asylum. It is difficult to determine the exact priority because these asylums developed from some religious institution. At any rate the insane were treated, according to the fashion of the day, in England at Bedlam as early as 1407, in France in the Charenton Asylum and possibly also in Spain. One can easily realize what these places were like when one recalls that the word Bedlam, even to this day, connotes disorder and "confusion worse confounded." It was not until 1792 that Pinel at Salpetriéré struck the chains and shackles from the inmates. It was not, however, until around 1840 that conditions began really to improve and even then until very recent years the straight-jacket was used. The next improvement was instituted through the influence of S. Weir Mitchell. In 1895, I think this was the year, the Association of Insane Asylum Superintendents, as it was styled, out of which the great American Psychiatric Association has grown, met in Chicago and invited Dr. Mitchell to address them. They expected a commendatory and laudatory address; but instead Dr. Mitchell excoriated them. He told them they were merely gaol keepers, that they were neglecting examination and treatment of their patients, that they kept no proper records, that they had developed no laboratories, that they did no autopsies and that they were throwing away wonderful opportunities to contribute to the science of medicine. They were howling mad. But they went back home, examined cases, started records, instituted treatment, opened laboratories and performed autopsies. Soon after this the term, insane asylum, gave way to state hospital and a person instead of being called crazy was termed mentally sick. New classifications and new nomenclature came into vogue and patients with distinct forms of insanity were segregated in different buildings.

The specialty of psychiatry was late in being born. Previous to the present century there were practically no great psychiatrists in the modern sense. Craft-Ebling, who belongs to the end of the nineteenth century and the early twentieth, was probably the first. I think Shakespeare knew as much and probably more psychiatry than any man up to Craft-Ebling. In truth, Shakespeare probably knew more psychiatry than many men making a specialty of it today. How he learned so much of "the mind diseased" is hard to understand. However, we have reason to believe that he was a keen observer and we have found out that when he came to London as a young man he boarded near Bedlam and is said to have spent much time talking to and observing the inmates. We know, too, that his daughter married Dr. Hall who was a cultured man interested in mental disease and he may have gotten much from Dr. Hall. The modern psychiatrist, though a lusty infant, is still in the diaper stage of his branch of the profession, and hence has much to learn. He must not swallow more of the Freuderian theory than he can digest lest he have cerebral dysentery and he must not clothe himself too warmly in modern psychology if he does not wish to become badly chafed and then also he must not lean too heavily upon instruments of precision, reports, files, standardization and statistics or he will never be able to walk alone.

Probably the two greatest mental giants that have ever appeared on earth are Leonardo da Vinci and Shakespeare. Leonardo was an illegitimate child; he sold ammunition discoveries and war implement designs out of his country; he bought birds in cages and took them outside of the city and set them free; he invented mechanical toys for dukes, highborn ladies and other grown-ups to get drunk and play with; he accepted money for paintings he never finished; he was in many lawsuits; while he was painting the Last Supper he would go to the picture, paint and brush in hand, stand in front of it six or eight hours and then go home without ever touching it; and he painted a lady whose smile just couldn't have had any sense to it for it has been keeping the world guessing for around five hundred years! Then there was Will Shakespeare, a shiftless boy, a poor scholar, who grew to be a village ne'er-do-well and who was arrested for poaching. He allowed himself to be seduced in

his teens by a woman eight years older than himself whom he was forced to marry and whom he deserted when she had presented him with twins —they making three children in all. Around fifty years of age he came back home, his handwriting having become almost illegible, and he died in a drunken spree, leaving a written curse to him who disturbed his bones and leaving his wife, in his will, only his second best bed! There is no telling what might have happened to Leonardo and Shakespeare if they had had a Freuderian analysis, abnormal psychology guidance and standardized regulation. It is possible that their conflicts would have been adjusted and that they would have been advised to become bricklayers—after they had been sterilized!

The Encyclopedia Brittannica says a significant thing—that the number of the insane in all civilized countries is about 1 to 300 and that variations of stress, drinking habits, disease epidemics, etc., vary the proportion but little. In a way this is comforting to one who hears on every hand of the great increase in insanity. I personally do believe there is an increase in the neuroses and psychoneuroses but these are not insane states. I have lived long enough to observe the decrease in paresis even if there has been an increase in, let us say, the number of insane from encephalitis. The insane now are not hidden in some attic or farmed out in the country or let run loose and, hence, we have become more insane conscious. I feel that with improvement in treatment we have a prospect of lessening the incidence of insanity—but we cannot accomplish this without proper and adequate institutions. It is up to you gentlemen to see that the great state of Florida does not lag behind.

A curved line from the Alabama border just beyond Pensacola through Jacksonville and Orlando to Key West is about 800 miles. On this line is one institution, at Chattahoochee, for the mentally sick. A line of similar length running from Gross, Florida, north, would take us past Baltimore and on or just off of this line would be the following state hospitals: one of Georgia, one of South Carolina, one of North Carolina, two of Virginia, St. Elizabeth's in Washington and the Sheppard and Enoch Pratt in Baltimore—seven major institutions, to say nothing of many small private psychiatric sanatoria. We can readily see how woefully inadequate is the care that Florida, a state superior in so many other respects, is giving her mentally diseased citizens. I have no personal interest in the matter except that of friendship but I do feel constrained to say that Florida, in my opinion, should have two other state hospitals—one let us say in the neighborhood of Orlando for the white and one elsewhere for the colored. I think the colored patients from Chattahoochee should be moved to the new colored institution. With these three institutions I can assure you Florida will not have too many. In Virginia we have four state hospitals for the insane, three white and one colored. They are all, I regret to say, crowded. At one of these institutions we have a separate department for the criminal insane, at another a department for drug addicts and inebriates. We also have a colony for the feebleminded and epileptic. In addition to these we have, under penal regulation, a farm for delinquent behavior cases.

Connected with some of the city hospitals should be a psychiatric pavilion for the diagnosis, temporary care and treatment of mental cases. This will prevent many acute cases from being committed to the regular state institutions for the insane and will obviate these unfortunates waiting in jails, almshouses and other unsuitable places for transfer. I understand there is a colony for the feebleminded and epileptic in Florida, but that it takes only white patients. I am of the opinion that there should be a similar institution for the colored. It is possible that this could be in connection with a colored insane institution if this were established.

At the new state hospital segregation could be well carried out. Florida, both in climate and topography, is adapted for the pavilion type hospital. Besides separation of the white and colored and of male and female patients the tuberculous insane should be segregated; buildings not too close together should be erected for the violent, the moderately affected and the convalescent patients; there should be a separate hospital building staffed with trained nurses rather than attendants for the surgically and medically ill; there should be a laboratory and pathology building; some arrangement should be made for separately caring for the criminal insane and for the inebriates; the grounds should be laid out not only to embrace dairy, garden and farm but fields for competitive sports—baseball, tennis, golf and other games. The executive building of a state hospital is usually the largest, most elaborate and most costly building of all, but in my opinion it is the least useful. I have neither the ability nor the desire to plan a state hospital for you nor for anyone else but I simply throw in these suggestions for what they are worth.

Florida, having such a large tourist and semi-resident population has a problem to solve greater than most states as to how to handle the insane who are residents and taxpayers of other states. I am not familiar with the Florida laws upon this subject, but I do think these people should not be Florida's responsibility except in so far as their temporary care is concerned until they can be transported to their homes.

I thoroughly realize that the program above suggested is an elaborate one and one that will involve considerable outlay. On the other hand, a state becomes rich, both materially and spiritually, which properly handles the problem of its defective citizens. Money spent in these institutions is saved in almshouses, jails, penitentiaries, in the burden of relief and in community care and normal citizens live in greater happiness, usefulness and security in a state which adequately looks after its mental hygiene.

Florida is to be congratulated upon the development of the State Hospital at Chattahoochee. I understand the normal capacity of this institution is 2700 patients and that it is now maintaining over 4000 patients, including, I believe, a certain number of narcotic addicts and voluntary patients, but that it does not take inebriates unless they develop a psychosis. Recently in making a study of pellagra I asked various institutions for information and pathological specimens of brains and spinal cords of patients dying of this disease. This information was supplied and specimens were sent me from Chattahoochee by Dr. Pound. I was gratified that the response was so prompt, intelligent and satisfactory. I wish it clearly understood that nothing I say in this address is a reflection, directly or indirectly, upon the Chattahoochee institution. In fact, I suspect that the authorities there, who must have their hands full, would welcome a sister institution. I do, however, thoroughly agree with the recent findings of the National Committee for Mental Hygiene in regard to the Chattahoochee institution having a medical superintendent and with a current editorial in the Florida State Medical Journal, by Dr. Ralph Greene, urging the profession to use all its influence in seeing that this hospital does have a medical superintendent. Politics should play no part in state hospital appointments or management.

In considering all of these matters there arises the question of private mental sanatoria and of the admission of pay patients to the state hospitals. It resolves itself into the ever-increasing problem of state medicine. My position on this question is, I hope, sane. I am definitely opposed to filling up state hospitals with well-off citizens. The state hospital should be eleemosynary. The enlargement and establishment of private pay mental sanatoria should be encouraged by the profession, by the citizens and by the state. If the paying patient cannot be accommodated in private institutions then it becomes, in my opinion, the state's duty to take care of them on a pay rate. But, the state hospital should be the largest referring factor of the private sanatoria.

A state hospital in addition to being adequately staffed should have access to a large consulting staff and these consultants should be modestly remunerated. The medical superintendent, and in my opinion every state hospital should have a medical superintendent and a business manager, of a state hospital should feel free to call upon internists and surgeons and specialists in every branch of medical science not only when a crisis arises, but in the ordinary course of gathering clinical data and in instituting treatment for special conditions.

And then, too, a state hospital should be an educational center for the dissemination of mental hygiene information. Clinics should be held at stated intervals; lectures should be given both to the profession and the public and carefully considered mental hygiene literature should be distributed. The relationship of conduct disturbance to mental states should be studied and correlated. For years I have maintained that gross conduct disturbance is largely a medical problem. Its prevention is far more important than the mere detection of the criminal and his punishment. Unfortunately the apparently simple method of sterilization, although advisable in certain instances, does not answer the question. I refer you to the editorial on sterilization in the Journal of the American Medical Association of May 12, 1934.

In closing allow me to say that I feel I have added but little to what you already know. I believe that Florida will meet her state hospital situation satisfactorily, just as she has met her other situations and that you of this state beloved by all other states have the good wishes of the whole country in your endeavors. But remember, gentlemen, that the adulation Florida receives carries with it the responsibility of you physicians and citizens and of those in political authority having the eyes of the other states turned upon you—may the light of your countenance increasingly shine!

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SAINT JOSEPH'S HOSPITAL

The Sisters of Saint Francis in Tampa held open house on September 30, 1934, preceding the official opening on October 1. Saint Joseph's Hospital is a modern and thoroughly equipped hospital with a capacity of seventy-five beds. The equipment consists of three operating rooms and delivery room. These rooms are done in colors pleasing to the eye and at the same time, do not affect the required amount of light. There is an x-ray department which is most complete, an autopsy room, as well as a clinical and pathological laboratory.

The Sisters are to be congratulated for opening so well equipped a hospital during the strenuous financial times that we are now going through.

Not many years past, the doctors of Florida were generally handicapped in their work in many communities, due to inadequate or no hospital facilities. Now there are probably ten hospitals where there used to be one in the state and many of them are working under the minimum standards of the American College of Surgeons. Not only have the hospitals increased in number and efficiency, but many of the smaller towns have private or community hospitals that are well equipped to take care of the average case.

We should be very thankful to the Sisters and other organizations that have made it possible for us to do better work.

SOME FACTS CONCERNING STATE HOSPITAL

You have been hearing a great deal lately concerning the State Hospital in Chattahoochee and you will probably hear a great deal more. We are trying to give you all the facts and details concerning the situation at that institution. Since it seems we are being completely ignored by the Governor and his cabinet and since we are making a concerted effort to change the conditions at the State Hospital, it is well that you be thoroughly acquainted with the situation there.

In the last issue of this Journal reference was made to Dr. Pound as being made the acting superintendent of the hospital upon the death of Dr. Folmar. It might be interesting to you to know some of the details concerning Dr. Pound's superintendency. When he was tendered the superintendency he accepted on the condition that he be allowed to select a layman to handle the business details. The Board of Commissioners of State Institutions informed him that they had on file many applications for the position of business manager at Chattahoochee and therefore did not give Dr. Pound the opportunity of making his choice. The Board thereupon sent their Purchasing Agent at Tallahassee to Chattahoochee to occupy the position of business manager. It was found that he was well beyond middle age, had had a stroke of apoplexy, and seemed to have the usual mental losses that go with such conditions. This was further complicated by impairment of ability to walk and impediment of speech due to the brain hemorrhage.

Due to his unfavorable condition of health, the doctor attempted to perform the duties of the business manager in addition to his own administrative duties. Later the doctor was, according to rumor, charged with not giving the business manager the opportunity of working independently. Later on, the doctor was called before the Board of Commissioners of State Institutions at Tallahassee and was informed by said board that he was held in high regard and his services as a doctor were desired. However, the doctor was informed that it was their purpose to place this sick man in the superintendency of the State Hospital at Chattahoochee. Therefore, the doctor was preemptorily demoted to the position of chief physician and a lay superintendent, whose health was in a precarious condition, was appointed to the position of authority over the entire affairs of the hospital. It is therefore readily seen

that the welfare of the hospital was not the first consideration in the minds of the Board of Commissioners of State Institutions when they made the appointment.

Since that time the superintendent resigned and the medical profession of this State has petitioned the Governor and his board in a resolution, setting forth various points wherein the hospital was not being operated for the best interest of the patients, to appoint a medical superintendent for that hospital. The board, over the protest of the medical profession, appointed a lay superintendent and one of his first acts has been to make a survey preliminary to transferring many of the so-called "harmless patients" back to the county poor houses. It took a century, almost, to get the insane out of the county poor houses. There the lunatic is locked in a cell, is forgotten and usually dies under conditions of extreme neglect. If the harmless cases were to be sent out of Chattahoochee the overhead expense in operating the Chattahoochee Hospital would rise to about five dollars per day per patient. Under these conditions caring for two thousand cases instead of caring for the four thousand they now have would amount to three and a half million dollars annually. The harmless cases are working in the laundry, on the farm, in the sawmill and are manufacturing shoes, brooms, rugs and other supplies.

Two murders have been committed by so-called "harmless" patients at Tampa recently. A nationally important kidnapping event was perpetrated by a patient at Louisville, Kentucky.

There are only eight doctors at Chattahoochee and, according to the minimum requirements, as recommended by the American Psychiatry Association, in the operation of mental hospitals, there should be no less than twenty-four doctors. It must be remembered that these people are sent there for treatment and not sent there for room and board.

There is at present a terrible practice of transporting men and women, white and colored, over the highways of the State in a hospital bus which, because of the distances traveled, necessitates over-night stops and the locking up of patients over night in one of the several county jails. There is a Jim Crow law in this state which seems to be thus an object of violation by the State itself. Certainly no right-thinking person can approve of the transporting of innocent white women in the same vehicle in which a desperate and possibly criminal maniac is manacled to the same seat.

It has long been the practice in this State to incarcerate insane people, who are sick people in every sense of the word, in county jails. They are not criminals and the placing of invalids in an atmosphere among criminals and amidst bolts and bars is not conducive to mental repose and in itself is prejudicial to their recovery. With the many hospitals over the state now, a hospital bed and attendants could be made available for a person mentally ill pending commitment of such patient by the court.

The Florida Medical Association feels that since the State of Florida will not correct the present evils at the State Hospital, it is our duty to put forth every effort for their correction. It is understood that the State officials at Tallahassee do not take seriously the fight we are making.

It is the duty of this Association to continue this fight and you are called upon to assist in every way you can.

(Signed) Homer Pearson, M.D.,
President,
Florida Medical Association, Inc.

CONSTITUTION AND BY-LAWS

A number of changes have been made in the Constitution and By-Laws since they were last published. These official changes are included in the reproduction of the Constitution and By-Laws which appear on the following pages.

In Article IV, Section 1 of the Constitution, the words "Life Members" have been added. To the same Article, Section 6, defining a Life Member, has been added.

In Chapter III of the By-Laws, the following has been added to Section 3: "Ample seating facilities shall be arranged for the House of Delegates, separate and apart from the seating facilities provided for visiting members of the Association." Section 16, providing for the certification of Delegates to the House of Delegates, has also been added to this Chapter.

In Chapter VIII, Section 1, "$10.00" has been deleted and "$7.50" inserted in lieu thereof.

CONSTITUTION

ARTICLE I.

Name of the Association

The name and title of this organization shall be the Florida Medical Association, Incorporated.

ARTICLE II.

Purposes of the Association

The purposes of this Association shall be to federate and bring into one compact organization the entire medical profession of the State of Florida, and to unite with similar Associations in other States to form the American Medical Association, with a view to the extension of medical knowledge, and to the advancement of medical science; to the elevation of the standard of medical education, and to the enactment and enforcement of just medical laws; to the promotion of friendly intercourse among physicians, and to the guarding and fostering of their material interests; and to the enlightenment and direction of public opinion in regard to the great problems of State medicine, so that the profession shall become more capable and honorable within itself, and more useful to the public in the prevention and cure of disease, and in prolonging and adding comfort to life.

ARTICLE III.

Component Societies

Component Societies shall consist of those county medical societies which hold charters from this Association.

ARTICLE IV.

Composition of the Association

Section 1. This Association shall consist of Members, Delegates, Honorary Members, Life Members, and Guests.

Sec. 2. *Members*—The members of this Association shall be the members of the component county medical societies.

Sec. 3. *Delegates*—Delegates shall be those members who are elected in accordance with this Constitution and By-Laws to represent their respective component societies in the House of Delegates of this Association.

Sec. 4. *Honorary Members* — Honorary and retired members of the Florida Medical Association may be elected by the House of Delegates or by the Executive Committee either directly or upon nomination officially made by a component County Medical Society. An honorary or retired member shall be exempt from all dues in this Association; shall not have the right to vote; shall be permitted to subscribe for the publication of the Association at a special price to be made by the House of Delegates or Executive Committee; shall have the right to attend meetings and be eligible to such other privileges as may be granted by the House of Delegates.

Sec. 5. *Guests*—Any distinguished physician may become a guest during any Annual Meeting upon invitation of the officers of this Association, and shall be accorded the privilege of participating in all of the scientific work for that Meeting.

Sec. 6. *Life Members*—Any member of the Florida Medical Association who has been an active member of the Association for 35 years shall be made a life member of the Association and exempt from all dues.

ARTICLE V.

House of Delegates

The House of Delegates shall be the legislative and business body of the Association, and shall consist of (1) Delegates elected by the component county societies, and (2), *ex-officio*, the officers of the Association as defined in this Constitution.

ARTICLE VI.

Meetings and Sessions

Section 1. The Association shall hold an Annual Meeting during which there shall be held daily not less than two Sessions which shall be open to all registered members, delegates, honorary members, life members and guests.

Sec. 2. The Association shall hold an Annual Meeting at the place selected by the House of Delegates at the preceding Annual Meeting. The date shall be fixed by the Executive Committee with the approval of the Committee on Arrangements of the entertaining society at least four months in advance.

Sec. 3. Special Meetings of either the Association or the House of Delegates may be called by the President.

ARTICLE VII.

Officers

Section 1. The Officers of this Association are to be a President, a President-elect, three Vice-Presidents, a Secretary, a Treasurer, and an Editor of the Journal. In the discretion of the Association, the offices of Secretary, Treasurer and Editor of the Journal may be held by one individual.

Sec. 2. All Officers are to be elected annually, and shall serve until their successors are elected and installed.

Sec. 3. The Officers of this Association shall be elected by the Association at noon on the last day of the Annual Meeting, and any member shall be eligible to any office named in the preceding section, but no person shall be elected to such an office who is not in attendance during that Annual Meeting (except the Secretary, Treasurer and Editor of the Journal) and who has not been a member of the Association for two years.

Sec. 4. THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC., shall be the official organ of the Association.

ARTICLE VIII.

Arrangement for Funds

Funds for meeting expenses of the Association are to be arranged for by the House of Delegates, by an equal per capita assessment on each county society to be fixed by the House of Delegates, or by voluntary contributions or bequests, and by profits of publications. Funds may be provided by the House of Delegates to defray the expenses of the Annual Meetings, for publications, and for such other purposes as it may deem proper.

ARTICLE IX.

Referendum

The General Session of the Association may, by a two-thirds vote, order a general referendum upon any question pending before the House of Delegates, and the House of Delegates may by a similar vote of its own members, or after a like vote of the General Session, submit any such question to the membership of the Association for a final vote; and if the persons voting shall comprise a majority of all the members, a majority of such vote shall determine the question, and be binding upon the House of Delegates.

ARTICLE X.

The Seal

The Association shall have a common Seal, with power to break, change or renew the same at pleasure.

ARTICLE XI.

Amendments

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates registered at that Annual Meeting, provided that such amendments shall have been presented in open session at the previous Annual Meeting, and shall have been sent officially to each component county society at least two months before the meeting at which final action is to be taken.

BY-LAWS

CHAPTER I.

Membership

Section 1. All members of Component Societies shall be privileged to attend all sessions and take part in all of the proceedings of the Annual Meeting, and shall be eligible to any office within the gift of the Association.

Sec. 2. The name of a physician upon the properly certified roster of members, or list of delegates, of a component society which has paid its annual assessment, shall be *prima facie* evidence of his right to register at

the Annual Meeting in the respective bodies of this Association.

Sec. 3. No person who is under sentence of suspension or expulsion from any component society of this Association, or whose name has been dropped from its roll of members, shall be entitled to any of the rights or benefits of this Association, nor shall he be permitted to take any part in any of its proceedings until such time as he has been relieved of such disability.

Sec. 4. Each member in attendance at the Annual Meeting shall enter his name on the registration book, indicating the component society of which he is a member. When his right to membership has been verified by reference to the roster of his society, he shall receive a badge, which shall be evidence of his right to all the privileges of membership at that meeting. No member or delegate shall take part in any of the proceedings of an Annual Meeting until he has complied with the provisions of this section.

Chapter II.

General Sessions

Section 1. The General Sessions shall include all registered members, delegates, honorary members, life members and guests, who shall have equal rights to participate in the proceedings and discussions and, except honorary members and guests, to vote on pending questions. Each General Session shall be presided over by the President, or in his absence or disability, or by his request, by one of the Vice-Presidents. Before it, at such time and place as may have been arranged, shall be delivered the annual address of the President, and the annual oration, and the entire time of the Meeting so far as may be shall be devoted to papers and discussions relating to scientific medicine.

Sec. 2. The General Session shall have authority to create committees or commissions for scientific investigations of special interest and importance to the profession and public, and to receive and dispose of reports of the same; but any expense in connection therewith must first be approved by the House of Delegates or the Executive Committee.

Sec. 3. Except by special vote, the order of exercises, papers and discussions as set forth in the official program shall he followed from day to day until it has been completed.

Sec. 4. No address or paper before the Association, except those of the President and Orator, shall occupy more than fifteen minutes in its delivery, and no member shall speak longer than five minutes, or more than once on any one subject.

Sec. 5. All papers read before the Association shall be its property. Each paper shall be deposited with the Secretary when read.

Chapter III.

House of Delegates

Section 1. The House of Delegates shall meet annually at the time and place of the Annual Meeting of the Association, and shall so fix its hours of meeting as not to conflict with the first General Session of the Association, or with the session held for the address of the President and the annual oration, and so as to give delegates an opportunity to attend the other scientific proceedings and discussions so far as is consistent with their duties. But if the business interests of the Association and profession require, it may meet in advance, or remain in session after the final adjournment of the Annual Meeting, or meet at the call of the President.

Sec. 2. Each component county society shall be entitled to send to the House of Delegates each year one delegate for every 20 members, and one for each major fraction thereof, but each county society holding a charter from this Association, which has made its annual report and paid its assessment as provided in this Constitution and By-Laws, shall be entitled to one delegate. Provided, that this annual report must be made to the Secretary of the State Association at least thirty days prior to the date of the Annual Meeting.

Sec. 3. A majority of the registered delegates shall constitute a quorum, and all of the sessions of the House of Delegates shall be open to members of the Association. Ample seating facilities shall be arranged for the House of Delegates, separate and apart from the seating facilities provided for visiting members of the Association.

Sec. 4. It shall, through its officers, Council, and otherwise, give diligent attention to and foster the scientific work and spirit of the Association, and shall constantly study and strive to make each Annual Meeting a stepping-stone to future ones of higher interest.

Sec. 5. It shall consider and advise as to the material interests of the profession, and of the public in those important matters wherein it is dependent upon the profession, and shall use its influence to secure and enforce all proper medical information in relation thereto.

Sec. 6. It shall make careful inquiry into the condition of the profession of each county in the State, and shall have authority to adopt such methods as may be deemed most efficient for building up and increasing the interest in such county societies as already exist, and for organizing the profession in counties where societies do not exist. It shall especially and systematically endeavor to promote friendly intercourse between physicians of the same locality, and shall continue these efforts until every physician in every county of the State who can be made reputable has been brought under medical society influence.

Sec. 7. It shall encourage post-graduate work in medical centers, as well as home study and research, and shall endeavor to have the results utilized and intelligently discussed in the county societies.

Sec. 8. It shall elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and By-Laws of that body in such a manner that not more than one-half, as near as may be, shall be elected in any one year.

Sec. 9. It shall, upon application, provide and issue Charters to County Societies organized to conform to the spirit of this Constitution and By-Laws.

Sec. 10. In sparsely settled sections it shall have authority to organize the physicians of two or more counties into societies to be designated by hyphenating the names of two or more counties so as to distinguish them from district and other classes of societies, and these societies when organized and chartered, shall be entitled to all the privileges and representation provided herein for county societies, until such counties may be organized separately.

Sec. 11. It shall divide the State into Councilor Districts, specifying what counties each district shall include, and when the best interests of the Association and profession will be promoted thereby, organize in each a district medical society, and all members of component county societies, and no other, shall be members in such district societies.

Sec. 12. It shall have authority to appoint committees for special purposes from among members of the Association who are not members of the House of Delegates, and such committees may report to the House of Delegates in person, and may participate in the debate thereon.

Sec. 13. It shall approve all memorials and resolutions issued in the name of the Association before the same shall become effective.

Sec. 14. It shall publish its proceedings in The Journal of the Florida Medical Association, Inc.

Sec. 15. It shall select the place for the next annual meeting.

Sec. 16. Each delegate representing a component society, before being seated, shall deposit with the Association's secretary or his duly authorized representative, a certificate signed by the Secretary of his component society, stating that he has been regularly elected a delegate by the component society. All delegates shall report at the registration desk upon arrival at the state meeting, exhibit their credentails and receive instructions regarding the meeting place and time of House of Delegates.

Chapter IV.

Election of Officers

All elections shall be by secret ballot, unless there is but one nominee for an office when the Secretary, upon motion duly seconded and carried, is empowered to cast the ballot of the Association for the nominee. A majority of the votes cast shall be necessary to elect.

Chapter V.

Duty of Officers

Section 1. The President shall preside at all meetings of the Association and of the House of Delegates; shall appoint all committees not otherwise provided for; shall deliver an annual address at such time as may be arranged; shall give a deciding vote in case of a tie, and shall perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession of the State during his term of office, and, as far as practicable, shall visit, by appointment, the various sections of the State and assist the Councilors in building up the county societies, and in making their work more practical and useful.

Sec. 2. The Vice-Presidents shall assist the President in the discharge of his duties. In the event of his death, resignation or removal, the First Vice-President shall succeed him. The President-elect shall be *ex-officio* member of all committees, without the power to vote.

Sec. 3. The Treasurer shall give bond in the amount of his yearly budget. He shall demand and receive all funds due the Association, together with bequests and donations, and shall have the care and arrangement of fiscal affairs of the Association. He shall subject his accounts yearly to audit by a Certified Public Accountant, and render an annual report of his doings to the second General Session of the Association. He shall charge upon his books the assessments upon each component County Society at the end of the fiscal year, which assessments he shall collect and make the proper credit for, and he shall perform such other duties as may be assigned him. All funds belonging to the Association shall be deposited in a National Bank to the credit of the Association. No money shall be drawn from this account except by proper voucher checks, serially numbered. The expenses of the Treasurer's bond and audit of accounts, shall be paid by the Association.

Sec. 4. The Secretary shall attend all sessions of the Association and of the House of Delegates, and shall keep minutes of their respective proceedings. He shall be custodian of all record books and papers belonging to the Association, except such as properly belong to the Treasurer, and shall keep account of and promptly turn over to the Treasurer all funds of the Association which come into his hands. He shall provide for the registration of members and delegates at the Annual Meetings. He shall keep a record of all the legal practitioners of the State, noting their status in relation to their county societies, and upon request shall transmit a copy of this list to the American Medical Association for publication. Insofar as it is in his power, he shall use the printed matter, correspondence and influences of his office to aid the Councilors in the organization and improvement of the county societies and in the extension of the power and usefulness of this Association. He shall conduct the official correspondence, notifying members of meetings, officers of their election and committees of their appointment and duties. He may employ such assistance as may be authorized by the House of Delegates or the Executive Committee. He shall annually make a report of his doings to the second General Session of the Association. In order that the Secretary may be enabled to give that amount of time to his duties which will permit of his becoming proficient, it is desirable that he should receive some compensation. The amount of his salary shall be $600.00 per annum.

Chapter VI.

Council

Section 1. The Council shall consist of one Councilor from each of the twenty-one councilor districts, to be appointed by the President. The President shall annually appoint a Chairman and a Secretary and the latter shall keep a record of its proceedings. It shall, through its chairman, make an annual report to the second General Session of the Association.

Sec. 2. Each Councilor shall be organizer, peacemaker and censor for his district. He is urged to visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession, and for improving and increasing the zeal of the county societies and their members. He shall make an annual report of his doings, and of the condition of the profession of each county in his district to each annual session of the Council.

Sec. 3. The Council shall be the Board of Censors of the Association. It shall consider all questions involving the rights and standing of members, whether in relation to other members, to the component societies or to this Association. All questions of an ethical nature brought before the House of Delegates, or the general sessions, must originate in the county society and shall be referred to the Council without discussion.

Chapter VII.

Committees

Section. 1. Regular Committees shall be the Executive Committee, a Committee on Scientific Work, a Committee on Legislation and Public Policy, a Committee on Publication, and a Committee on Medical Education and Hospitals. They shall be appointed by the President. The Committee on Arrangements shall consist of the component society where the annual session is to be held.

Sec. 2. The Executive Committee shall consist of the President and Secretary, *ex-officio,* and three members to be appointed by the President. It shall consider and act upon all matters of business pertaining to the Association in the interval between the Annual Meetings, and shall render a report of its actions to the second General Session.

Sec. 3. The Committee on Scientific Work shall consist of three members appointed by the President. It shall determine the character and scope of the scientific proceedings of the Association, subject to the provisions in the Constitution and By-Laws. It shall prepare and issue a program for each Annual Meeting, announcing the order in which papers, discussions, and other business shall be presented. The number of papers to be read before each Annual Meeting shall be left to the discretion of the Committee on Scientific Work but no member shall be permitted to present a paper in successive years.

Sec. 4. The Committee on Legislation and Public Policy shall consist of three members and the President and Secretary. Under the direction of the House of Delegates it shall represent the Association in securing and enforcing legislation in the interest of the public health and of scientific medicine. It shall keep in touch with professional and public opinion, shall endeavor to shape legislation so as to secure the best results for the whole people, and shall utilize every organized influence of the profession to promote the general influence in local, state and national affairs and elections. Its work shall be done with the dignity becoming a great profession and with that wisdom which will make effective its powers and influence. It shall have authority to be heard before the entire Association upon questions of great concern at such time as may be arranged during the Annual Meeting.

Sec. 5. The Committee on Publication shall consist of the Editor and two others to be appointed by the President, and shall have referred to it all reports on scientific subjects and all scientific papers and discussions heard before the Association. It shall be empowered to curtail or abstract papers and discussions, and any paper referred to it which may not be suitable for publication may be returned to the author. All papers read before the Association shall be the property of the Association. The Editor shall receive an annual salary of $600.00, provided that this be paid out of the funds of The Journal.

Sec. 6. The Committee on Arrangements shall consist

of the component society in the territory in which the Annual Meeting is to be held. It shall, by committees of its own selection, provide suitable accommodations for the meeting-places of the Association and of the House of Delegates, and of their respective committees, and shall have general charge of all the arrangements. Its Chairman shall report an outline of the arrangements to the Secretary for publication in the program, and shall make additional announcements during the meeting as occasion may require.

Sec. 7. The Committee on Medical Education and Hospitals shall consist of three members to serve; one for a period of three years, one for two years, and one for one year, the vacancy created each year being filled by appointment to serve a three-year term. This Committee shall serve in this state for the Council on Medical Education and Hospitals of the American Medical Association, and shall have referred to it all questions pertaining to hospitals and medical education.

Chapter VIII.

Assessments and Expenditures

Section 1. An assessment of $7.50 per capita on the membership of the component societies is hereby made the annual dues of the Association; of this amount $3.00 shall be set aside as a subscription for The Journal. The Secretary of each county society shall forward its assessment, together with its roster of all officers and members, list of delegates, and list of non-affiliated physicians of the county, to the Secretary of this Association thirty days in advance of each Annual Session.

Sec. 2. Any county society which fails to pay its assessment, or make the reports required, on or before the date above stated, shall be held as suspended, and none of its members or delegates shall be permitted to participate in any of the business or proceedings of the Association or of the House of Delegates until such requirements have been met.

Sec. 3. All motions or resolutions appropriating money shall specify a definite amount, or so much thereof as may be necessary for the purpose indicated, and must be approved by the House of Delegates on a call of the ayes and noes.

Sec. 4. Any county society shall have authority to remit the dues of its Secretary, to the State Association, for duties performed in accordance with the Constitution and By-Laws.

Chapter IX.

Rules of Conduct

The principles set forth in the Code of Ethics of the American Medical Association shall govern the conduct of members in their relation to each other and to the public.

Chapter X.

Rules of Order

The deliberations of this Association shall be governed by parliamentary usage as contained in Roberts' Rules of Order, unless otherwise determined by a vote of its respective bodies.

Chapter XI.

County Societies

Section 1. All county societies now in affiliation with this Association or those that may hereafter be organized in this State, which have adopted principles of organization not in conflict with this Constitution and By-Laws, shall, upon application to the Council, receive a charter from and become a component part of this Association.

Sec. 2. As rapidly as can be done after the adoption of this Constitution and By-Laws, a medical society shall be organized in every county in the State in which no component society exists, and charters shall be issued thereto.

Sec. 3. Charters shall be issued only upon the approval of the House of Delegates and shall be signed by the President and Secretary of this Association. The House of Delegates shall have authority to revoke the charter of any component county society whose actions are in conflict with the letter or the spirit of this Constitution and these By-Laws.

Sec. 4. Only one component medical society shall be chartered in any county. Where more than one county society exists, friendly overtures and concessions shall be made, with the aid of the Councilor for the District if necessary, and all of the members brought into one organization. In case of failure to unite, an appeal may be made to the Council, which shall decide what action shall be taken.

Sec. 5. Each county society shall judge of the qualification of its own members, but, as such societies are the only portals to this Association and to the American Medical Association, every reputable white and legally registered physician who is practicing, or who will agree to practice, non-sectarian medicine, shall be entitled to membership. Before a charter is issued to any county society, full and ample notice and opportunity shall be given to every such physician in the county to become a member.

Sec. 6. Any physician who may feel aggrieved by the action of the society of his county in refusing him membership or in suspending or expelling him, shall have the right of appeal to the Council which, upon a majority vote, may permit him to become a member of an adjacent county society.

Sec. 7. In hearing appeals, the Council may admit oral or written evidence as in its judgment will best and most fairly present the facts, but in case of every appeal, both as a Board and as individual Councilors in district and county work, efforts at conciliation and compromise shall precede all such hearings.

Sec. 8. When a member in good standing in a component society moves to another county in this State, his name, upon request, shall be transferred without cost to the roster of the county society into whose jurisdiction he moves.

Sec. 9. A physician living on or near a county line may hold his membership in that county most convenient for him to attend, on permission of the society in whose jurisdiction he resides.

Sec. 10. Each county society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, moral and material condition of every physician in the county; and systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it embraces every qualified physician in the county.

Sec. 11. Frequent meetings shall be encouraged, and the most attractive programs arranged that are possible. The younger members shall be especially encouraged to do post-graduate and original research work, and to give the society the first benefit of such labors. Official position and other preferments shall be unstintingly given to such members.

Sec. 12. At the time of the annual election of officers each county society shall elect a delegate or delegates to represent it in the House of Delegates of this Association, in the proportion of one delegate to each twenty members or major fraction thereof, and the Secretary of the society shall send a list of such delegates to the Secretary of this Association, at least ten days before the Annual Sessions.

Sec. 13. The Secretary of each county society shall keep a roster of its members, and a list of the non-affiliated registered physicians of the county, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this State, and such other information as may be deemed necessary. He shall furnish an official report containing such information, upon blanks supplied him for the purpose, to the Secretary of this Association, thirty days in advance of

each Annual Meeting, and at the same time that the dues accruing from the annual assessment are sent in. In keeping such roster the Secretary shall note any changes in the personnel of the profession by death, or by removal to or from the county, and in making his annual report he shall be certain to account for every physician who has lived in the county during the year.

Chapter XII.

Amendments

These By-Laws may be amended at any Annual Meeting by a majority vote of all the delegates present at that meeting after the amendment has laid upon the table for one day.

CORRESPONDENCE

Chicago, October 26, 1934.

For the Secretaries of the Constituent State and Territorial Medical Associations and For the Editors of State Medical Journals:

Medical Advisory Committee

On October 12, 1934, I forwarded a bulletin to the secretaries of all constituent state and territorial medical associations. The first part of that bulletin, pertaining to the Committee on Economic Security, was marked "Confidential" for the reason that at that time we entertained some hope that the organized medical profession would be asked to be officially represented on the Medical Advisory Committee which is in process of organization by the Executive Director of the Committee on Economic Security. We have now received official information from Prof. Edwin E. Witte, Executive Director of the Committee on Economic Security, that in connection with the organization of the Medical Advisory Committee selections have been made on an individual basis without asking for nominations from any organization.

In a letter received from Professor Witte under date of October 13, written in reply to a letter from the Secretary of the American Medical Association, the following information is submitted:

1. The Director of the Bureau of Medical Economics of the American Medical Association will be invited to go to Washington to discuss "the economic aspects of the problems of medical care of people in very low income groups."

2. The Medical Advisory Committee now being organized will be composed of physicians selected on an individual basis. At the time Professor Witte's letter was written, not all of those who had been invited to serve on the Medical Advisory Committee had replied.

3. The names of the prospective members of the Medical Advisory Committee would not be disclosed. (In a letter received from Professor Witte under date of October 22, it is stated that he hopes "to announce the Medical Advisory Committee in the very near future," and that he is "planning committees of consultants in the fields of dentistry, hospital management and public health.")

4. The Committee on Economic Security will be glad to have suggestions from the American Medical Association or its officers on any phase of its work at any time. (It is presumed that the Committee will likewise welcome suggestions from state medical associations or from the officers of those organizations.)

5. Professor Witte will make an effort to visit the offices of the American Medical Association "shortly before the New Year."

6. The assurances of cooperation extended by the Board of Trustees and officers of the American Medical Association are sincerely appreciated.

Accompanying Professor Witte's letter of October 22 is a mimeographed copy of an "Information Primer" of the Committee on Economic Security. This is not dated but was evidently released before October 13, since a statement based on this release appeared in the New York Times for that date. In the "Primer" it is stated that the report of the Committee on Economic Security to the President is due to be made on December 1, 1934, and will not be made public until released by the President. It is also stated that among the studies initiated by the Committee on Economic Security is one on "Provisions for Meeting the Economic Risks of Illness," and that Mr. Edgar Sydenstricker and Dr. I. S. Falk, both of whom are in the employ of the Milbank Fund, are in charge of this particular study. Professor Witte informs me that neither Mr. Sydenstricker nor Doctor Falk will be a member of the Medical Advisory Committee of the Committee on Economic Security.

Dr. Walter L. Bierring, President of the American Medical Association, has been invited to serve as a member of the Medical Advisory Committee and has accepted. The invitation was addressed to Doctor Bierring as an individual and not as President of the American Medical Association. I have heard that the President of the American College of Surgeons and the President of the American College of Physicians have received similar invitations, though this infor-

mation did not come from official sources in Washington.

It seems reasonable to assume that the President of the United States, after the report of the Committee on Economic Security has been submitted to him on or about December 1, will decide whether or not plans for providing some system of sickness insurance will be included in the program of social insurance which it is reported he will submit to Congress.

A member of the last Congress, who is seeking reelection in the November elections, has addressed letters to physicians in Illinois in which it is stated that he has been informed that a bill providing for sickness insurance will be introduced at the next session of Congress. I am informed that similar statements have been made by other Congressmen. The Illinois candidate for Congress has asked physicians to give him the benefit of their views with respect to sickness insurance. Printed material dealing with this subject has been forwarded to him and to other candidates for election as Congressmen.

A letter received at the offices of the American Medical Association from the President of the National Congress of Parents and Teachers states that a letter from the Twentieth Century Fund was before the Board of the National Congress of Parents and Teachers asking that body to "endorse Pres. Roosevelt's plan of Health Insurance," and was rejected by the Board.

In the "Information Primer" released by the Committee on Economic Security, the following statement is made:

"Following the approach outlined by the President, the Committee is trying to draw up a comprehensive program which will give protection to the individual from all the vicissitudes and hazards of modern life—unemployment, accident, sickness, invalidity, old age, and premature death.

"It is, of course, not contemplated that this program shall go into effect in its entirety immediately, but it is planned to give Congress and the country a 'look ahead' as well as some recommendation for immediate action, to the end that there may be developed, from the outset, a unified plan for economic security."

It seems quite probable that no hearings on sickness insurance will be held under the auspices of the Committee on Economic Security. It is, of course, presumed that if any bill providing for sickness insurance is submitted to Congress, official hearings will be held by the committee to which such bill will be referred.

Since the American Medical Association and many of its constituent medical associations have gone on record in opposition to sickness insurance, it is extremely desirable that the views of the organized medical profession should be made known to members of Congress and to candidates for election as members of that body. It is suggested, therefore, that the officers of constituent state medical associations and of component county medical societies and the members of the legislative committees of these bodies immediately develop plans for acquainting members of Congress and candidates for election to that body with the expressed official views of the organized profession in the United States pertaining to sickness insurance. Most of the members of Congress and all the candidates for election *are now at home.*

In the meantime, an earnest effort will be made further to inform the Executive Director of the Committee on Economic Security and the members of that Committee concerning the official attitude of the American Medical Association with respect to sickness insurance and the basis of the Association's opposition to any plan involving governmental control of medical practice.

Very sincerely yours,

(Signed) Olin West, M.D.,

Secretary, American Medical Association.

MEETING OF FLORIDA EAST COAST MEDICAL ASSOCIATION

The Florida East Coast Medical Association held its seventh annual convention at Orlando, October 19 and 20. On the afternoon of the 19th, the following symposium on Backache was given:

"Orthopedic Viewpoint," Dr. A. H. Weiland, Coral Gables.

"Medical Viewpoint," Dr. E. C. Swift, Jacksonville.

"Urologic Viewpoint," Dr. A. G. H. Holmes and Dr. M. M. Coplan, Miami.

"Roentgenologic Viewpoint," Dr. F. J. Payton, Miami.

"Gynecologic Viewpoint," Dr. C. J. Collins, Orlando.

"Surgical Viewpoint," Dr. Edward Jelks, Jacksonville.

At the evening session, held at the Orlando Country Club, addresses were given by Dr. J. R. Chappell, President of the Orange County Medical Society; Dr. Leigh F. Robinson, President of the Florida East Coast Medical Association; Dr. Homer Pearson, President of the Florida Medical Association, and Dr. J. H. Pound, Medical

Director of the Florida State Hospital at Chattahoochee. The guest speaker of the evening was Dr. Beverley R. Tucker, Professor of Nervous and Mental Diseases of the Medical College of Virginia. His discourse was on "The Mentally Ill Citizen—His Care, Especially as Applied to Florida."

During the morning session on the 20th, the following scientific program was presented:

"Foreign Bodies in the Air Passages," Dr. Julian H. Buff, Orlando.

"Tuberculosis and the General Practitioner," Dr. W. A. Claxton, Jacksonville.

"Mosquito Control Work in Broward County," Dr. B. F. Butler, Hollywood.

"A Proper Evaluation of the Psychic Element in Medical and Surgical Practice," Dr. S. A. Shoemaker, Orlando.

"Peptic Ulcer From a Medical Standpoint," Dr. W. C. Pumpelly, Ft. Pierce.

At 12:30 the annual election of officers took place with the following results:

President—Dr. H. A. Walker, Miami Beach.

First Vice-President—Dr. Spencer A. Folsom, Orlando.

Second Vice-President—Dr. E. B. Hardee, Vero Beach.

Secretary-Treasurer—Reddin Britt, St. Augustine.

St. Augustine was selected as the next meeting place of the Association.

STATE NEWS ITEMS

Dr. and Mrs. H. C. Dozier of Ocala spent their vacation at Blowing Rock, N. C., recently. They also visited other points of interest before returning home.

* * *

Dr. J. M. Hoffman of Pensacola conducted a symposium on Cancer Control at Marianna on September 23.

* * *

Dr. Laura Mae Hobbs of Miami announces the removal of her office to 653 S. W. Second St.

* * *

Dr. J. H. Pound of Chattahoochee was a visitor in Jacksonville on October 22.

* * *

Dr. and Mrs. Joseph H. Lucinian and son, Joseph, Jr., of Miami have returned from a vacation in the North where Dr. Lucinian visited medical clinics in Baltimore, Philadelphia and Boston. He also attended the American Roentgen-Ray meeting in Pittsburgh where he took the examination of the National Board of Radiology.

Dr. A. T. Cobb has assumed the duties of prison physician at Raiford. He was formerly connected with the State Hospital at Chattahoochee.

* * *

Dr. Leigh F. Robinson of Ft. Lauderdale has returned from Boston where he attended the fracture course given by the Harvard Medical School at the Massachusetts General Hospital. He also attended the Congress of the American College of Surgeons.

* * *

Drs. V. D. Stone and S. Ward Fleming of West Palm Beach recently returned by boat from the North where they attended the Boston meeting of the College of Surgeons.

* * *

Drs. A. B. Connor, O. C. Brown, D. E. Carter and E. M. Hendricks of Ft. Lauderdale have returned from their vacations spent in the North.

* * *

Much interest should be aroused by the announcement which has just been made that the American Urological Association, with over 1,000 members, has granted permission for the establishment of a "Southeastern Branch" in the territory composed of the following states: Alabama, Georgia, Florida, Louisiana, North Carolina, South Carolina, and Tennessee. In this area there are already over seventy-five urologists who are members of the national organization, and a much larger number who, although they do not belong to the A. U. A., take an active interest in city or state urological societies.

An increased attention by the medical profession of the Southeast to urological problems should result from the clinical meetings of this branch of the American Urological Association. And since special provision has been made in the Constitution and By-Laws of the Branch Society to include as members of the organization almost all physicians residing in the southeastern territory who have a special interest in urology and desire to become members, the meetings of the Society should bring together the urologists of the Southeast and strengthen, by concentration, the efforts already being made by the local state and city organizations to improve urological standards.

A meeting of the Southeastern group will be held in Atlanta, December 7 and 8. For further particulars of this meeting, write Dr. E. S. Gilmer, Citizens Bank Building, Tampa.

* * *

Dr. E. N. McKenzie of Miami has returned from a trip to the North and East.

Dr. C. F. Roche of Miami Beach has returned from a pleasure trip to Boston and other points in the East.

* * *

Dr. C. E. Tumlin of Miami visited clinics in New York, Detroit and Cleveland recently.

* * *

The Florida Midland Medical Society held its meeting at Bartow, October 25 and 26. Dr. T. M. Rivers of Kissimmee, head of the Society, presided during the sessions.

* * *

Dr. Duncan Owens of Miami Beach has returned from Rochester, Minn., where he attended the Clinic of Middle and Western States. He also attended the banquet of the Committee of One Hundred.

* * *

Dr. R. Sam Moseley of Miami recently took a post-graduate course at the Children's Memorial Hospital in Chicago.

* * *

Dr. and Mrs. Raymond H. Center of Clearwater announce the birth of a son, James Hugh Center, on October 31.

* * *

Dr. Herbert E. White of St. Augustine attended the meeting of the Society of Clinical Surgery held at the Yale Medical School in New Haven, October 26 and 27. Dr. White was the guest of Dr. J. J. Morton, Professor of Surgery at Rochester University.

* * *

The following members of the Florida Medical Association registered at the recent meeting of the American College of Surgeons held in Boston:

John R. Chappell, Orlando.
Julius C. Davis, Quincy.
W. J. Lancaster, Tampa.
T. O. Otto, Miami.
Bascom H. Palmer, Miami.
Leigh F. Robinson, Ft. Lauderdale.
Vale D. Stone, West Palm Beach.
G. C. Tillman, Gainesville.
Frederick J. Waas, Jacksonville.
Carol C. Webb, Pensacola.
J. Ralston Wells, Daytona Beach.
Herbert E. White, St. Augustine.

* * *

A meeting of the Public Relations Committee was held Sunday evening, November 4th, at the home of Dr. and Mrs. J. Ralston Wells of Daytona Beach. The members and their wives present enjoyed a very tasty buffet supper, following which a lengthy business meeting was held.

The Florida Radiological Society held their regular fall meeting at the United States Veterans' Hospital, Bay Pines, October 27th. As the guests of Dr. Ralph E. Stevens and the Staff of the Hospital, they were graciously entertained.

Dr. Frederick K. Herpel, President, presided and Dr. W. McL. Shaw, Vice-President, served as Secretary in the absence of Dr. F. J. Payton. Informal presentation and discussion of cases was carried out in the morning and afternoon, concluding with a business meeting which followed the dinner in the evening at the Seminole Club, St. Petersburg.

The Society passed a resolution stating that they disapproved of any hospitalization plan which included the services of any physician and that a hospital should not practice medicine in any guise whatsoever.

COMPONENT COUNTY SOCIETIES

COLUMBIA COUNTY MEDICAL SOCIETY

THE COLUMBIA COUNTY MEDICAL SOCIETY WAS THE SECOND SOCIETY TO SUBMIT DUES FOR 1935. HOWEVER, IT IS THE FIRST SOCIETY TO PAY 100% OF DUES FOR THE COMING YEAR.

The Secretary of the Society, Dr. T. H. Bates, makes the following comment on the Society's outstanding achievement: "This early payment of dues is made possible by virtue of the county society having taken over the burden of physical examinations of all of the FERA workers in the canning plant just opened here. The fee for examination was one dollar each and with the organization of a clerical force and the division of duties among the physicians, it was possible to complete the examining of a large number in a short period of time. Since we frequently have been called upon to render somewhat similar service without being paid, we found this a satisfactory arrangement and the payment of our 1935 dues has been made painless."

* * *

DADE COUNTY MEDICAL SOCIETY

The following program was presented at the regular meeting of the Dade County Medical Society, held in the Huntington Club Rooms, Miami, Friday evening, November 2:

"The Common Cold," D. H. Grimes, Miami.
"Anginal Syndrome and Coronary Thrombosis," E. Sterling Nichol, Miami.

DUVAL COUNTY MEDICAL SOCIETY

At the regular meeting of the Duval County Medical Society, held at the Mayflower Hotel, Jacksonville, Tuesday evening, November 6, the following symposium on Cancer comprised the scientific program:

Cancer Control—Gerry R. Holden.

Cancer of the Cervix and Uterus (lantern slides)—J. H. Hartman.

Cancer of the Breast (lantern slides)—H. A. Peyton.

The discussion was opened by Drs. F. J. Waas, T. S. Field, W. M. Shaw and C. C. Collins.

The new Finance Committee of the Duval County Medical Society is composed of Drs. Theo. G. Croft, Chairman; E. T. Sellers, J. Knox Simpson, T. S. Field and Robert McIver. According to a resolution passed at a previous meeting, this important committee is composed of the President of the Society, the two immediate past Presidents of the Society, the present Chairman of the Economics Committee and the past Chairman of that committee.

* * *

PINELLAS COUNTY MEDICAL SOCIETY

By invitation of Colonel T. S. Troy, the Pinellas County Medical Society met at the United States Veterans' Hospital for a dinner-clinic meeting conducted by the Hospital Staff at 6 p. m., Friday, November 2.

The Pinellas County Medical Society was the first of the component societies to send in dues for 1935. As usual, a new and unique form of statement was mailed to society members, which met with gratifying results. A note on the bill read: "Free. A beautiful 22x37 steel etching of the Yosemite Valley mounted on light sepia to the first 20 members paying dues. Our Reputation Must Be Maintained." The "steel engraving" turned out to be a one-cent Yosemite Valley postage stamp pasted on the back of a membership card. On the envelope containing the card the note appeared "With Apology for omission of 'mm' on bill."



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Jacksonville, Florida

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VOLUSIA COUNTY MEDICAL SOCIETY

The regular monthly meeting of the Volusia County Medical Society held in DeLand, October 9th was devoted to honoring Dr. and Mrs. G. A. Davis of that city on their fiftieth wedding anniversary. Dr. Davis graduated from medical school in 1890. Dr. J. Ralston Wells of Daytona Beach was toastmaster. Dr. Roy Howe, as president of the Volusia County Medical Society, gave a brief speech. Mrs. W. C. Chowning, New Smyrna, as president of the Woman's Auxiliary of the Volusia County Medical Society gave the toast. The toastmaster next called on Dr. L. B. Bouchelle, as the next oldest member of the Volusia County Medical Society. Mrs. Joseph Taylor was then called on as one of the Committee in charge of Arrangements. Mrs. Roy Howe, past president of the Auxiliary, also proposed a toast. At this point Dr. Davis responded to speeches and toasts. Mrs. J. Ralston Wells presented a gold vase to Mrs. Davis as a gift from the Woman's Auxiliary. The dinner was held at the Putnam Hotel, DeLand. At each place was a picture of Dr. and Mrs. Davis, with the legend 1884-1934. After the banquet those present repaired to the parlors where Mrs. Chowning poured coffee and where they were delightfully entertained by several vocal selections and an orchestra.

A short business session was later held and Dr. Fred Puleston, Daytona Beach, and Dr. M. Josie Rogers, also of Daytona Beach, were taken into the Volusia County Medical Society.

MRS. MCMURRAY HOSTESS TO MEMBERS OF MEDICAL AUXILIARY AND DOCTORS

Mrs. E. R. McMurray, president of the Florida State Medical Auxiliary, was hostess at a picnic luncheon given at Kissengen Springs, near Bartow, Sunday afternoon. Members upon arriving in the little city of Bartow were met by Boy Scouts who were stationed at every turn of the road to direct them to the meeting place. Mrs. McMurray in her very gracious manner greeted the guests with a most cordial welcome.

A large pavilion surrounded by a soft carpet of green grass and moss covered trees, and overlooking a beautiful crystal lake provided an ideal spot for the meeting place. Bathing was enjoyed by a number of the guests.

The business meeting of the joint boards was called to order by Dr. Gordon H. Ira, chairman of the Florida State Medical Advisory Board. Dr. Ira read a very interesting letter from Dr. Olin West, of the National Advisory Board, presenting a number of things that might be accomplished by the Woman's Auxiliary to the Florida State Medical Association.

Mrs. McMurray outlined briefly the things she would like to accomplish during the year, naming increased membership as the outstanding need.

During the board meeting, plans were outlined for the coming year, chief of which was the whole-hearted cooperation of all auxiliaries with the cancer prevention program in the State. Six other definite forms of work were decided upon which were to be presented to each auxiliary in the form of a charge by Dr. Homer Pearson, President of the Florida State Medical Association. The meeting adjourned for lunch.



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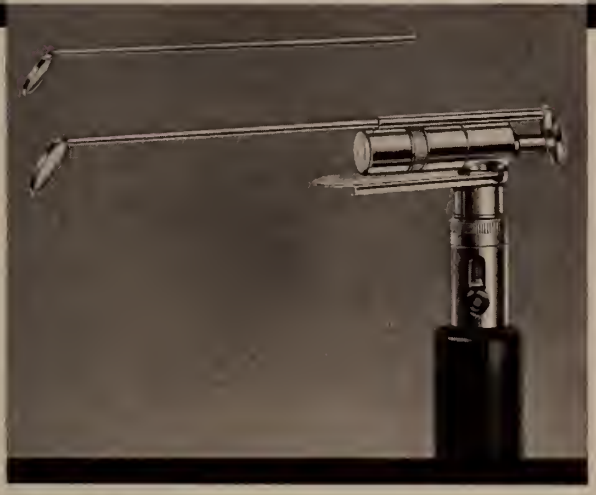
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Over against the spring were a number of tables arranged informally at which the guests were seated picnic style and served a bounteous barbecued chicken luncheon.

Immediately following the luncheon, the meeting was again called to order by Dr. Gordon H. Ira. The duties of each officer were discussed and the program outlined in the first business session, reviewed and approved by members present. There being no further business, the meeting adjourned with a general vote of thanks to the hostess, Mrs. E. R. McMurray, for her gracious hospitality in making the occasion a great success and one long to be remembered.

Those attending the picnic were Dr. and Mrs. Gordon H. Ira, Mrs. E. W. Veal and Mrs. S. M. Copeland of Jacksonville, Dr. and Mrs. Eugene G. Peek of Ocala, Dr. and Mrs. Walter A. Weed and Dr. and Mrs. John F. Wilson of Lakeland, Mrs. J. E. Taylor of DeLand, Mrs. J. Ralston Wells and Mrs. Alexander B. White of Daytona Beach, Dr. and Mrs. J. W. McMurray, Miss Helen McMurray and Mrs. E. R. McMurray of Bartow.

* * *

A copy of the following letter has been sent to every County Auxiliary in the State. Since this is the first definite program of work that has been assigned to us, let us hope that every individual member will cooperate, that the Woman's Auxiliary may become of indispensable value to the Florida Medical Association:

"After a thorough consideration of all work at hand by the board of the Woman's Auxiliary to the State Association in cooperation with the State Advisory Board, I present to you and to each County Auxiliary in the State of Florida the following charge for this year's work, and ask that you and your society cooperate to the best of your ability with State officers in their endeavor:

"*First:* Let each member at all times hold herself in readiness to serve on health committees of any outside organization.

"*Second:* Assist in the dissemination of good health literature by means of an enlarged circulation of Hygeia.

"*Third:* Give your whole-hearted cooperation to the program of cancer prevention, and arrange if possible one public presentation of cancer prevention material in your county, several if advisable, at a time acceptable to the State program.

"*Fourth:* Assist in organization of new County Auxiliaries.

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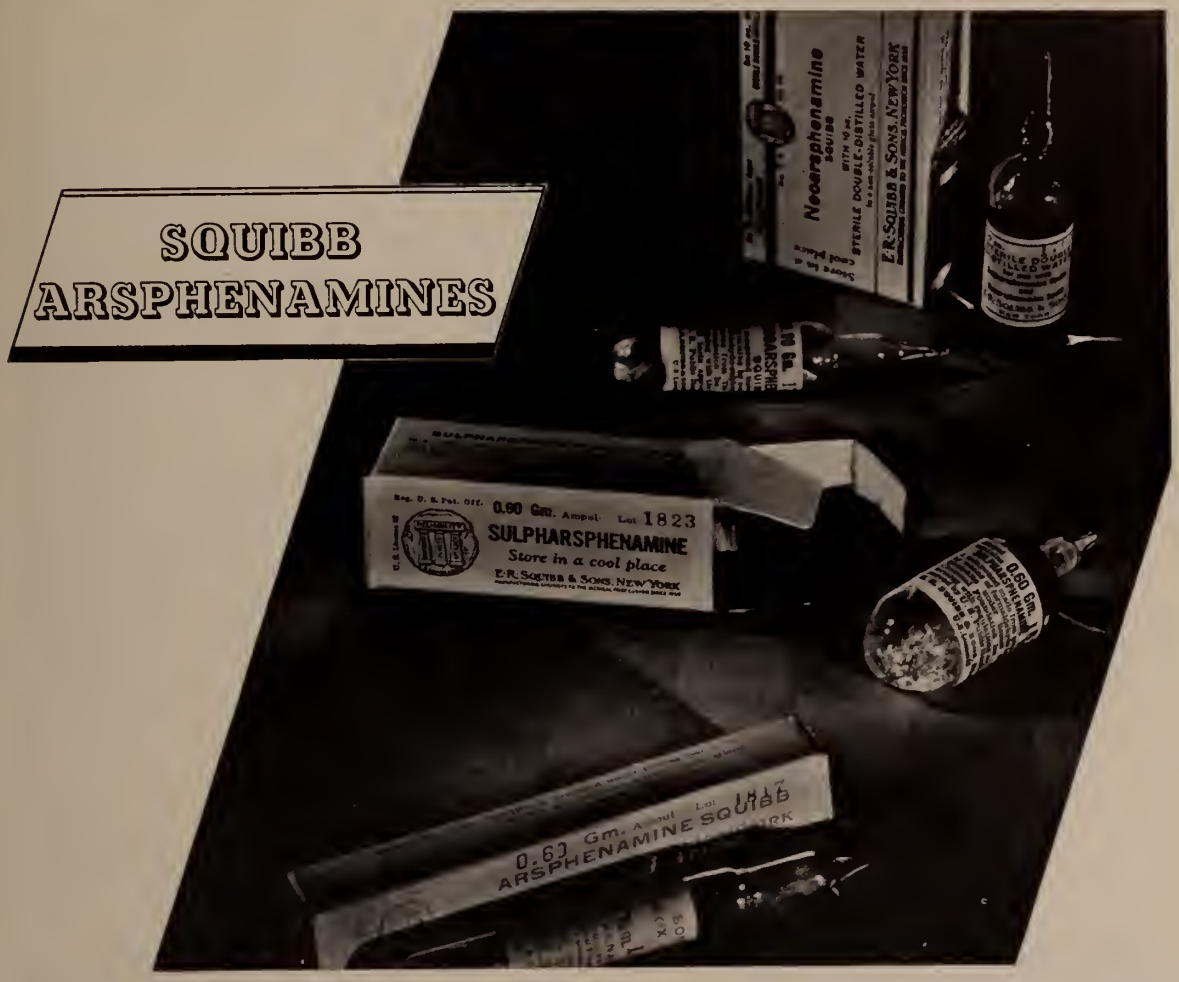
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"Sixth: Present to as many organizations as possible the talk on 'The Necessity of Health Cards for Household Servants.'

"Seventh: Use at least one Study Envelope during the year.

"The time has come when a well organized Woman's Auxiliary in every county can be a great aid to the State Society—therefore we ask for your whole-hearted cooperation.

"Very respectfully,
"Homer Pearson, M.D.,
"President Florida Medical Association."

* * *

Duval Medical Auxiliary Holds Meeting

The Woman's Auxiliary to the Duval Medical Society met Thursday afternoon at the home of Mrs. O. P. Broadbent, with the president, Mrs. Gordon H. Ira, presiding.

Officers serving this year are: Mrs. Gordon H. Ira, president; Mrs. A. K. Wilson, vice-president; Mrs. O. P. Broadbent, secretary; Mrs. Edward Jelks, treasurer.

Chairmen of standing committees are: Program, Mrs. A. K. Wilson; Social, Mrs. John H. Mitchell; Public Relations, Mrs. E. W. Veal; Hygeia, Mrs. J. H. Owens; Philanthropic, Mrs. Banks Goodale; Historian, Mrs. S. M. Copeland; Parliamentarian, Mrs. William Kirk.

Mrs. A. K. Wilson led an interesting program, beginning with current events on birth control, given by Mrs. William Kirk, Mrs. Theodore G. Croft, Mrs. R. R. Killinger and Mrs. A. B. Quasser.

The leader then introduced the guest speaker, Leroy MacGowan, who gave an illustrated lecture on "Heredity."

All were impressed by the facts brought out in this lecture that a person is developed not only by heredity, but greatly by environment and education, which teaches him to make the best of what he has and, in this way, can, to a great extent, overcome unfortunate heredity.

After the program, the guests assembled in the dining room where delicious tea was served. The table was laid with a beautiful handmade cloth and centered with cut flowers. Pouring tea was Mrs. Frederick Waas, while the coffee urn was presided over by Mrs. Croft. Mrs. Broadbent was very ably assisted in taking care of her

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Members attending this meeting were Mrs. R. R. Killinger, Mrs. Edward Jelks, Mrs. Banks Goodale, Mrs. Theodore Croft, Mrs. William Kirk, Mrs. O. P. Broadbent, Mrs. Neil Alford, Mrs. A. H. Wilkinson, Mrs. A. B. Quasser, Mrs. A. K. Wilson, Mrs. Gordon H. Ira, Mrs. John H. Mitchell, Mrs. E. W. Veal, Mrs. J. H. Owens, Mrs. Herrman H. Harris, Mrs. B. A. Chapman, Mrs. Lucien Y. Dyrenforth, Mrs. Ralph N. Greene, Mrs. S. M. Copeland, Mrs. Robert M. Baker, Mrs. J. W. Hayes, Mrs. David Schneider, Mrs. George Richardson, Mrs. W. G. Harris, Mrs. Ernest Milam and Mrs. F. J. Waas.

* * *

Marion County Auxiliary

Members of the Marion County Medical Auxiliary enjoyed a luncheon meeting Saturday in Dunnellon at the home of Mrs. A. G. Brown. A delicious luncheon was served by the hostess following a brief business session. The menu consisted of fruit cocktail, chicken salad in tomato cups, asparagus, green peas, sweet potato souffle, stuffed celery, buttered rolls, ice cream, cake and coffee.

The remainder of the afternoon after luncheon was spent in preparing health folders which will be mailed to various points over the county. It was decided at this meeting that the members of the auxiliary would hold a benefit card party sometime early in October. More definite arrangements for this party will be announced at a later date.

Local members of the auxiliary enjoying Mrs. Brown's hospitality were: Mrs. T. H. Wallis, Mrs. E. G. Peek, Mrs. William Cumming, Mrs. E. G. Lindner, Mrs. Walter Hood and Mrs. J. E. Chalker.

* * *

Marion County Auxiliary held their regular monthly meeting in October at the home of the President, Mrs. E. G. Lindner, on East Fifth street, Ocala. At this meeting plans were made for a benefit bridge party, which was held in the dining room of the Hotel Marion, when some one hundred and thirty people enjoyed the fascinating game.

It was also decided at this meeting to place Hygeia Magazine in all the schools of the city.

A social half hour was enjoyed with the hostess and delightful refreshments were served.



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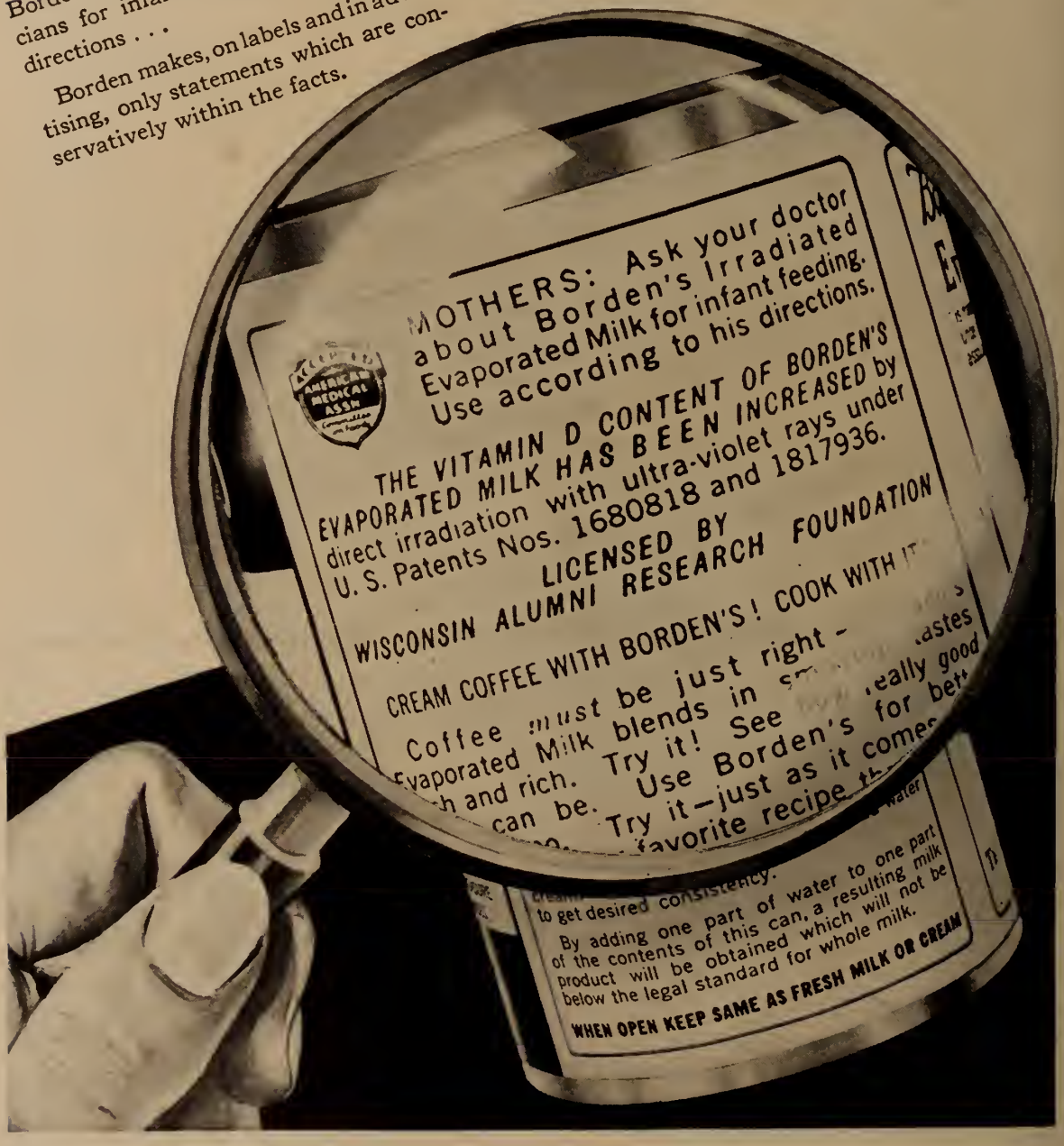
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SCHEDULE OF MEETINGS—COMPONENT SOCIETIES FLORIDA MEDICAL ASSOCIATION

COUNTY SOCIETY	SECRETARY	MEETINGS				Dues Paid.
		Date	Time	Place	Luncheon?	
Alachua	Harry M. Merchant, M.D., Gainesville.	2nd Tuesday	12:00 Noon	White House Gainesville	Yes.	90%
Bay	Allen H. Miller, M.D., Millville.					71%
Brevard	I. K. Hicks, M.D., Melbourne.	2nd Tuesday		Varies	Yes.	67%
Broward	O. C. Brown, M.D., Ft. Lauderdale.	Last Wednesday.	8:00 P.M.	Elks' Hall Ft. Lauderdale	No.	94%
Columbia	T. H. Bates, M.D., Lake City.	1st Monday	7:30 P.M.	Blanche Hotel Lake City		100%
Dade	Robert T. Spicer, M.D., Miami.	1st Friday	8:30 P.M.	Club Room Huntington Bldg. Miami	Occasionally.	95%
DeSoto-Hardee-Highlands	L. W. Martin, M.D., Sebring.	2nd Tuesday	8:00 P.M.	Varies	Yes.	93%
Duval	B. F. Woolsey, M.D., Jacksonville.	1st Tuesday	8:15 P.M.	Mayflower Hotel Jacksonville	No.	83%
Escambia	J. M. Hoffman, M.D., Pensacola.	2nd Tuesday	8:00 P.M.	Board of Health Building Pensacola	No.	76%
Hillsboro	John S. Helms, Jr., M.D., Tampa.	1st Tuesday	8:00 P.M.	Tampa Municipal Hospital Tampa	No.	100%
Jackson	Lewis Pierce, M.D., Marianna.	2nd Tuesday	7:30 P.M.	Hotel Chipola, Marianna	Yes.	91%
Lake	W. L. Ashton, M.D., Umatilla.	1st Thursday	12:30 P.M.	Eustis	Yes.	94%
Lee	Robley D. Newton, M.D., Ft. Myers.	3rd Friday	7:30 P.M.	Lee Memorial Hospital Ft. Myers	No.	100%
Leon-Gadsden-Liberty-Wakulla-Jefferson	O. G. Kendrick, M.D., Tallahassee.	Quarterly	3:00 P.M.	Varies	Yes.	100%
Madison	Geo. O. Davis, M.D., Madison.					100%
Manatee	W. D. Sugg, M.D., Bradenton.	3rd Tuesday	7:00 P.M.	Whitfield Country Club Bradenton	Yes.	100%
Marion	Richard C. Cumming, M.D., Ocala.	3rd Thursday	12:30 P.M.	Marion Hotel Ocala	Yes.	100%
Monroe	W. R. Warren, M.D., Key West.	1st Sunday	9:00 P.M.	Varies	Yes.	100%
Orange	John A. Pines, M.D., Orlando.	3rd Wednesday	8:30 P.M.	Varies	No.	100%
Palm Beach	R. Henry Baldwin, M.D., W. Palm Beach.	4th Monday	8:00 P.M.	Good Samaritan Hospital W. Palm Beach	No.	100%
Pasco-Hernando-Citrus	Geo. R. Creekmore, M.D., Brooksville.	2nd Thursday	7:00 P.M.	Varies	Yes.	100%
Pinellas	O. O. Feaster, M.D., St. Petersburg	1st Friday	8:00 P.M.	Assembly Room, 5th floor, P. & L. Bldg. St. Petersburg	No.	100%
Polk	J. R. Boulware, Jr., M.D., Lakeland.	2nd Wednesday in Feb., Apr., June, Aug., Oct., Dec.	1:00 P.M.	Lakeland	Yes.	98%
Putnam	E. W. Warren, M.D., Palatka.	2nd Thursday	7:00 P.M.	James Hotel, Palatka	Yes.	100%
St. Johns	Reddin Britt, M.D., St. Augustine.	3rd Tuesday	8:30 P.M.	Varies	Yes.	100%
St. Lucie-Okeechobee-Indian River-Martin	J. D. Parker, M.D., Stuart.	3rd Thursday	8:00 P.M.	Varies	Yes.	100%
Sarasota	J. E. Harris, M.D., Sarasota.	2nd Tuesday	8:30 P.M.	Varies	Occasionally.	100%
Seminole	J. T. Denton, M.D., Sanford.	2nd Monday	7:00 P.M.	City Hospital Sanford	Yes.	100%
Sumter	W. E. Mitchell, M.D., Coleman.	2nd Tuesday		Varies	No.	100%
Taylor	C. A. O'Quinn, M.D., Perry.	Last Friday	8:00 P.M.	Dixie-Taylor Hotel Perry	Yes.	100%
Volusia	Joseph H. Rutter, M.D., Daytona Beach.	2nd Tuesday	7:30 P.M.	Varies	Yes.	94%
Walton-Okaloosa	A. G. Williams, M.D., Lakewood.	3rd Thursday	8:00 P.M.	Varies	Occasionally.	100%

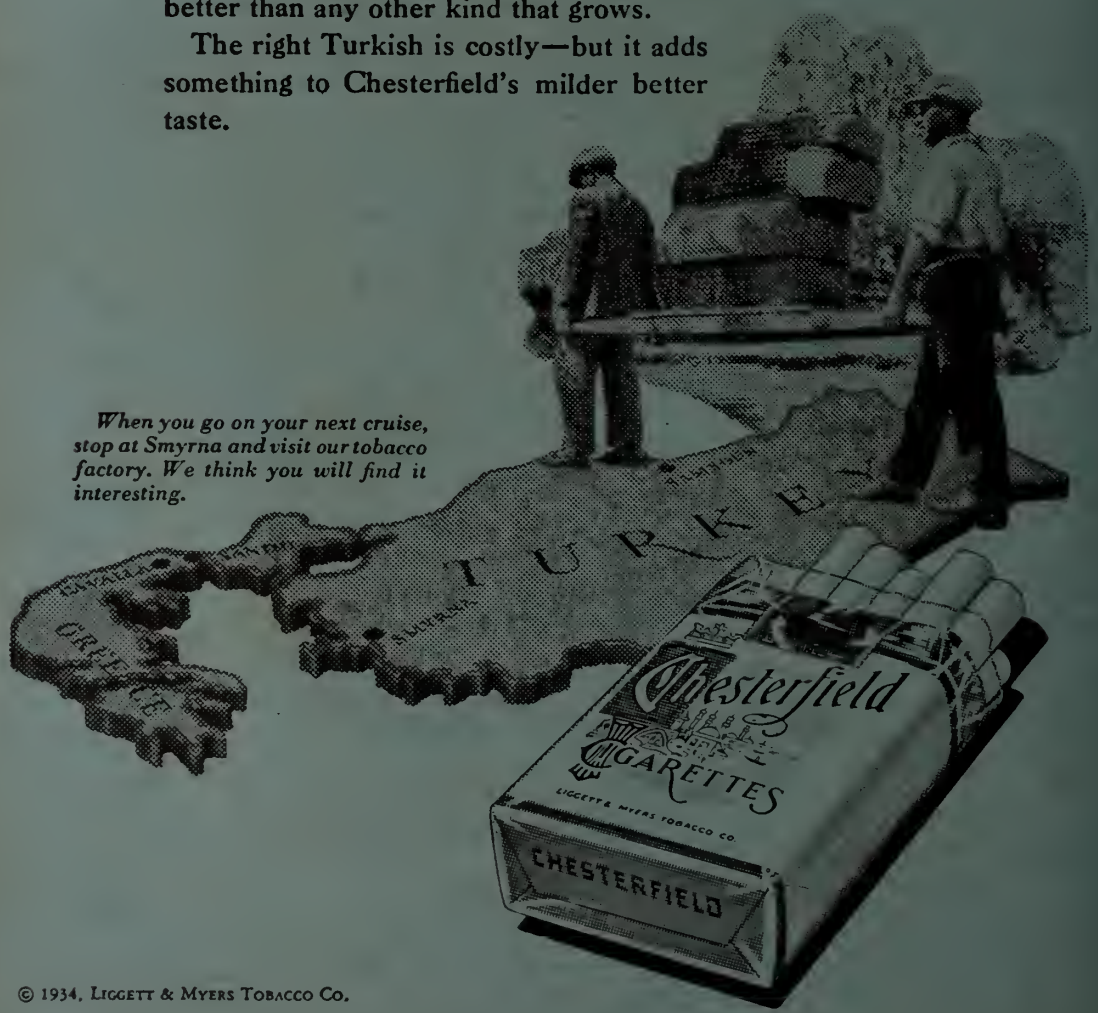
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NEXT SESSIONS Florida Medical Association, Ocala, May 13, 14, 15, 1935.
Southern Medical Association, San Antonio, November 13-16, 1934.
American Medical Association, Atlantic City, June 10-14, 1935.

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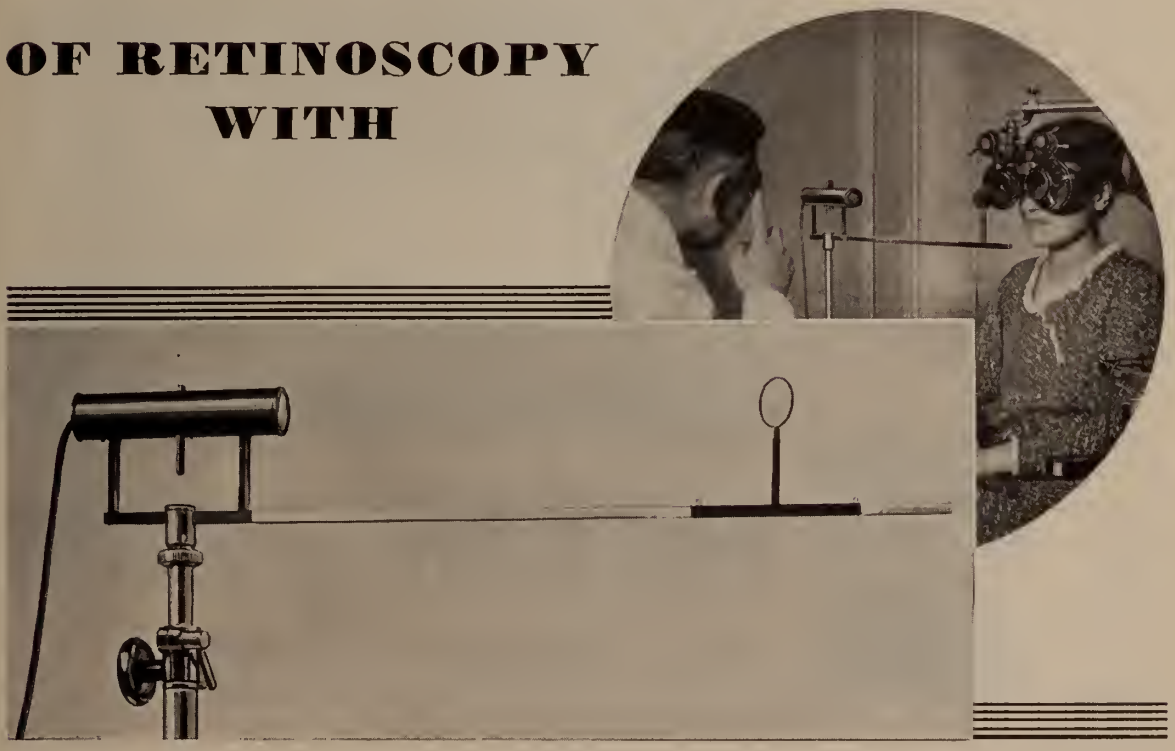
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X-RAY DIAGNOSIS AND SURGICAL MANAGEMENT OF GASTRIC AND DUODENAL LESIONS*

Bundy Allen, M.D.,
John R. Boling, M.D.,
Tampa.

It is not our idea in this paper to enter into a discussion involving the choice between medical and surgical treatment of gastric and duodenal ulcer. We know, as you do, that there are those who believe that all ulcers should be operated upon, while others seem to believe that surgery has little to offer. There is a happy medium to be found between these two opinions, which we believe offers the most satisfactory results.

Realizing that duodenal ulcers practically never become carcinomatous, it is safe and logical in those that are not over a year old, and in which there is no evidence of perforation, obstruction or bleeding, to try medical treatment. Small gastric lesions are also suitable for medical treatment.

In a paper on "The Roentgen Observations of Duodenal Lesions," Allen[1] presented a number of interesting slides to illustrate a number of the various types of lesions of the stomach and duodenum under discussion.

Gastric lesions vary and the character and type of the involvement which is shown in the cuts materially assists in the decision as to the best method of procedure and whether the treatment indicated is medical or surgical. These slides also illustrate or guide the surgeon in the type and extent of the operative procedure to best remove the involved area or to at least relieve the pathological condition and restore as nearly as possible the normal function.

The bulk of our present discussion will be taken up with the various types of operation indicated for the different lesions of the duodenum and stomach. No one type of procedure will be suitable for all lesions. We believe one should approach an operation on the stomach or duodenum with an open mind, being prepared to do the type of operation indicated after the abdomen is opened, noting the size and location of the pathology, the condition of the surrounding structure, keeping in mind the condition of this individual patient, the mortality associated with types of operation adaptable to this lesion, and the probable results. All of these things go into the final choice of technique to be followed.

There is no field in surgery, except it be brain work, that requires more judgment than does this. It is only after the lesion can be seen and handled, and the adjacent organs inspected, that the decision as to what is to be done should be made.

Ulcers of the stomach and duodenum differ in races and in geographical locations. In the past it has caused us some concern to note in the writings of many men the seeming prevalence of multiple ulcers. We have been concerned lest we might have overlooked other ulcers when there apparently was only one. In our experience multiple ulcer has been a great deal less common than single lesions, or at least our findings have been so.

Considering our lack of multiple lesions, Walters[4] stated that in Germany, Austria and Hungary the characteristic feature is the multiplicity of lesions, both of antrum and pylorus and duodenum, whereas in France and the United States the ulceration tends to localize. It is therefore apparent why surgeons in the first named countries should find it so often advisable to do extensive resections, while those here find less extensive operations better. The more radical resections run mortality of from 5 to 25 per cent, while in the simpler operations the mortality is 1.5 per cent or less.

As stated above, in the selection of the operation to be done numerous things are to be taken into consideration. The fact that the duodenum is the physiological emptying place for the stomach makes it therefore better prepared for the reception of the acid contents of the stomach than any other section of the gut. It is logical to expect a more nearly normal function of the stomach and duodenum following any operation that will continue to empty the stomach contents into the place normally prepared to receive it. To be borne in mind is that in all lesions of the stomach and duodenum there tends to be a

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spasm of the pyloric muscles, and it is wise by some means to eliminate this condition.

Gastro-Enterostomy:

This operation is one of the simplest of stomach operations, and has a wide field of usefulness. In this operation, as you know, the first part of the jejunum is anastomosed to the stomach, usually to the posterior wall.

Gastro-enterostomy was at one time hailed as a cure for all digestive disturbances, and an enormous number were done in conditions in which the operation was contra-indicated. No doubt many of you have seen it done in cases in which no ulcer or other pathology could be found, in vain hopes of relief. This, of course, brought the procedure into disrepute. It is a good operation in many cases, and has now taken its true place and much good is accomplished by it.

Balfour[2] reported relief in 87 per cent of five hundred cases of gastro-enterostomy for duodenal ulcer. These cases had not responded to other types of therapy. Mortality was 1.8 per cent of one hundred stomach ulcers. Gastro-enterostomy gave relief in 79 per cent. This operation gives better results in older patients with obstructive lesions. Judd feels that in younger patients excision of the ulcer and removal of the pyloric sphincter offer better results.

In large lesions of the duodenum and pyloric end of the stomach, with much induration and fixation of the gut, and in large bleeding lesions of the duodenum, especially in those past middle age, simple gastro-enterostomy is indicated, this being especially true in the obstructing type ulcer, or where ulcer has developed after pyloroplasty. The mortality is low and satisfactory results are obtained in from 65 to 85 per cent of the cases. Should the symptoms not be relieved, re-operation will probably show marked change in the pathology; the inflammation and induration will be greatly lessened, thereby removing greatly the mechanical difficulties of operation of a more radical type.

Pyloroplasty

Pyloroplasty means plastic operation on the pyloris. In this the pyloric sphincter is cut and the opening made larger, usually with removal of the ulcer. This is more nearly the physiological operation than any other. It was first described by Heineke-Mikulicz, later by Finney, Horsley and others. The Finney and the Horsley types are the ones of choice now.

Like other operations on the stomach, its field of usefulness is more or less limited. Horsley says: "As a rule, the less the pathology, the stronger the indication for pyloroplasty." It is indicated in limited small ulcers in the anterior duodenum or stomach near the pylorus, or where V-shaped excision of ulcer elsewhere in the stomach is done, or in narrow stenosis of pylorus. It is not indicated in large indurated ulcers, nor in posterior and multiple ulcers, nor where there are many adhesions about the duodenum. I prefer the Horsley type where it is adaptable, because of its simplicity and ease. The Finney has a little wider field, but is considerably more of an operation and needs more freedom of duodenum than the Horsley type. In both operations the ulcer is excised and the sphincter cut. Forty per cent are suitable for this operation.

Deaver[3] favors resection of outer half of the pyloric sphincter, without opening the lumen of the gut, and states that this operation should be performed in: (1) cases of peptic ulcer without organic pyloric obstruction; (2) cases of pylorospasm associated with other abdominal lesions; and (3) cases of hyperchlorhydria without an organic basis.

Resection:

In those lesions about the pylorus, the first part of the duodenum and the pyloric end of the stomach, not adaptable to pyloroplasty pylorectomy or partial gastrectomy should be done. This includes large or multiple ulcers about the pylorus, especially ulcers of the pyloric end of the stomach, and cancer. Billroth resections I and II, or modifications of the same, are entirely satisfactory. His operation I consists in uniting the stump of the duodenum to that of the stomach after pylorectomy. In his operation II, where the two ends could not be united, both ends are closed and posterior gastro-enterostomy done.

Polya modified the Billroth II to unite a loop of jejunum to stump of stomach, thereby saving considerable time in operation and enlarging the gastric capacity. Balfour modified the Polya by bringing the anastamosis anterior to the transverse colon rather than behind.

In small ulcers of the stomach other than those described, a simple V-shaped resection with pyloroplasty or gastro-enterostomy is indicated. Where this is not adaptable because of the size, a sleeve resection should be done. Resection should be done in carcinoma of stomach where there is not definite metastasis to liver or distant organs, no wide involvement of gastro-hepatic omentum, nor involvement of pancreas. The resection should be high and is often difficult.

It frequently involves some courage on the part of the operator, but it offers the only possible chance, and unless definitely contra-indicated by above mentioned involvement, should be attempted.

There is one important thing we want to bring out here, if we may digress a moment. That is the necessity for careful post-operative treatment. We often hear patients make the remark that they would rather be operated on than diet. Following operation, diet is just as important for six months to a year as in any other form of treatment, and it should be insisted upon.

With a proper selection of the operation, the results of stomach and duodenal surgery are, we believe, far more satisfactory than is commonly thought, and the mortality is sufficiently low to warrant its wide application. Relief is obtained in 85 per cent of cases. The fact that there remain 10 to 15 per cent that are no better following one or more operations, leaves great room for improvement. However, this can be said about any surgical or medical treatment of practically any lesion.

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DISCUSSION

Dr. W. M. Shaw, Jacksonville:

Drs. Allen and Boling have given us an excellent demonstration of the diagnosis of these intestinal lesions, and I wish to confine my discussion to their part of the presentation.

I don't believe they discussed these lesions in children. I wish to show the films of two children with gastro-intestinal lesions.

The barium meal remains the best method of diagnosing these lesions, and the barium meal is only as good as the roentgenologist giving it. It is easy to overlook these lesions in children but we have found that if you will examine properly you will find them.

(Films)

This first film represents a stomach and duodenum in a child six years of age. The history is that he came out of a theatre, fainted, which was followed by a very severe hemorrhage both by bowel and vomiting from the stomach. He was given a blood transfusion and these films were made about one week later. The lesion was seen on the first portion of the duodenum just outside of the pylorus. An x-ray diagnosis of duodenal ulcer was made. He was quite anemic and still losing blood. At operation a large ulcer was found on the first portion of the duodenum. That was three years ago. He has had no trouble since. This case demonstrates that children can and do have these lesions which we most often see in adults.

The next case is that of a seventeen year old girl. She was very nervous and had been neurotic for several years. She was undernourished and complained of pain in the left abdomen.

Barium meal study showed immediately a large filling defect in the cardiac end of the stomach which was noted with the fluoroscope. The filling defect extended down through the pylorus and into the duodenal cap or first portion. The study was continued over a period of twenty-four hours. An x-ray diagnosis of trichobezoar or hair ball in the stomach was made. Careful questioning brought out the fact that she had a habit of chewing up bits of hair. Her finger nails were bitten closely.

After the free barium passed through the stomach the first day of the examination the shape of the stomach and first portion of the duodenum remained outlined with the barium coated hair.

The patient was operated upon and a large hair ball removed. Further film study of the hair ball after surgical removal shows barium infiltrated deeply into the mass of hair. Her recovery was uneventful. We have not heard of her since she left the hospital three years ago.

I show these two cases because they were both found in children and because of their unusual interest from a diagnostic point of view.

Dr. L. B. Dickerson, Clearwater:

I enjoyed thoroughly Drs. Allen's and Boling's paper relating to gastric ulcers and other conditions. There is just one thing to be borne in mind—that the x-ray picture is not always positive unless it is corroborated by clinical findings. I have recently seen two cases, positive in their x-ray findings, and both relieved by other methods than surgery, with immediate clearing up of the symptoms found at that time.

There are so many operative procedures when the stomach is involved, all the way from a simple ulcer excision to a complete gastrectomy, that to my mind gastric surgery requires a great sense of surgical judgment in operating on any gastric lesion. For instance, a simple gastro-enterostomy, the most commonly used, relieves a great

many cases of gastric ulcer, probably more than any other type. The simpler the operative procedure, the less trauma to the stomach, the better results you should expect, provided you take care of the physiological functioning of that stomach. More than any other cardinal principle in gastric surgery that is a potent fact which should be kept in mind. The peristaltic action of the stomach and the physiological functioning of the stomach should be prime factors considered in gastric operative procedures on all stomachs. Pyloroplasty is probably next to the simplest procedure except a simple excision of a small ulcer, and probably gives all of the results that could be desired, when the ulcer is favorably located.

A great many patients are operated upon with gastro-enterostomies regardless of what type of lesion is present, and in these cases the results are often not what they should be, nor what the patient expects. Any gastro-enterostomy which is followed by a jejunal ulcer or recurrent gastric ulcer, that calls for a secondary operation rather brings it into disrepute among a large class of operators.

Therefore, the principal factor underlying gastric surgical procedure seems to be to keep in mind the peristaltic action of the stomach and its physiological function with the site of the lesion taken into account. No gastro-enterostomy will prove satisfactory where a partial gastrectomy is clearly indicated, so the type of surgery must be made to fit the type of the lesion.

Dr. John R. Boling, Tampa (concluding):

I wish to thank Drs. Shaw and Dickerson for their kind discussions. Of course we know that the x-ray man is not infallible but appreciate the fact that he has the diagnosis of the duodenal lesions down to a very fine point.

When a competent roentgenologist has diagnosed a small ulcer in the first part of the duodenum but due to the fact, as is often the case, this does not affect the local external findings, and the surgeon when he picks up the gut finds no adhesions and no evidence of ulcer, if he has confidence in the x-ray man then I think it behooves him to open the duodenum and search for the lesion. As shown by these pictures, the ulcer may be there and still show no evidence on the outside of the gut. No harm is done if it is not found on inspection of the inside of the gut, and as this is the only possible way to find some of these lesions, this procedure I am sure is warranted.

FIBROID TUMORS*

Lloyd J. Netto, M.D.,
West Palm Beach.

Introduction

The subject matter of this paper deals with a common type of pathology that confronts doctors in every branch of medicine from the beginning to the end of their professional lives. For that reason it is as important to the general practitioner as to the surgeon or gynecologist and I earnestly hope that it will prove of sufficient interest to all.

In preparation for this paper I have tried to thoroughly review the literature on the subject and present in an understandable manner the present day ideas pertaining to the various phases of fibroid tumors of the uterus, adding what has been gained from a relatively small series of cases from the surgical service of the Good Samaritan Hospital.

Historical Review

Uterine myoma was first described in the Second Century by Galen, who called it "sclerома" and described it as "a rather hard tumor arising from any portion of the uterus, due for the most part to chronic inflammation." Hippocrates and Salius both described "uterine stone" delivered from the vaginas of elderly maidens.

"Fleshy-tubercle," "dermoid," "fibrocartilaginous-chancroid," and "subcartilaginous-tumor" were other early designations of this condition.

At the present time the term "fibroid" and the term "myoma" are most commonly used. The first is accredited to Rokitansky and the latter to Virchow, as part of his "myoma-levicellulare."

The operation for excision of submucous tumors at the uterine orifice was first proposed by Velpeau and was carried out for the first time by Amussat about 1845. From 1825 the operation of laparotomy had been done for ovarian cysts and other adnexal pathology but the presence in the abdomen of myomatous growths was viewed with alarm and they were left untouched. Chelins of Heidelberg removed a pedunculated abdominal tumor in 1830. During this period a few surgeons removed the uterus by laparotomy but the operative mortality was appalling, being from 50% to 87% in the hands of various

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operators. Notably in this early group was Burnham of Lowell who first removed the uterus for a fibroid in 1853. His method was to employ a double ligature around the cervix and amputate above allowing the stump to fall back into the abdomen. This operation he repeated on fifteen patients of which number twelve died. A short while later Koeberle and Pean, two of the great surgeons of the period, conceived the idea of fixing the pedicle formed by the cervix and broad ligaments outside the abdomen in the lower angle of the wound, where it would become detached by dry gangrene in about three weeks. Others applied the same principle using specially devised clamps or rubber ligatures instead of transfixing needles. Strangely crude as this method appears to be, it became relatively efficient and successful, reducing the former mortality rate to 28%.

The next advance was in the form of vaginal hysterectomy which was originally developed by Pean in France. The original operation consisted in removing the tumor per vaginum, piece by piece. Pean performed the operation 248 times with but four deaths, a mortality of 1.6%, and which has been very little improved upon.

Apostoli, in 1899, introduced the treatment by electrolysis for myomata and made great claims for his method. Subsequent serious complications and sequelae in patients treated proved the method to be worthless and it was promptly abandoned.

The next chapter in history brings us to the introduction of radium and x-ray which methods will be discussed in another part of the paper.

Etiology

Since Galen first advanced the theory that chronic inflammation was for the most part responsible for the production of fibroids, many competent investigators have studied the problem, but no undisputed proof has been offered to explain the origin. No "mother-cell" or "fibroid-rest" has been found or demonstrated. Meyer and Becher of Berlin, supported by others, have rather conclusively proved that uterine fibroids arise from normal muscle in the uterine wall independently of any so-called anlage. Everyone who has operated upon or observed these tumors very closely has noticed their weird manners of growth and their strange degenerations. A recent article by Witherspoon and Butler of New Orleans seems to cover the subject well. They report an incidence of 4 to 1 in colored women as compared to white women, and with almost invariable association with chronic pelvic inflammation. This causes damage to the ovaries with resultant glandular dysfunction and overproduction of estrin, the growth-promoting hormone, and this disturbance stimulates fibroid development. To explain the stimulus in the absence of such inflammation in white women and the virgins, they have found long standing passive congestion or follicle cysts of the ovaries as probable cause for a like chain of events. In our series of cases a similar condition prevailed in practically every instance. No case was entirely free of some adnexal disturbance.

Symptoms and Diagnosis

What percentage of fibroids of the uterus grow to various sizes and then regress or entirely disappear after the menopause without ever making their presence known I cannot say. But a very large number never produce any symptoms at all and are found only during examination for some other condition or at autopsy. Tumors as large as 85 pounds in weight have been reported as being symptomless except for the noticeable abdominal enlargement. On the other hand the very small submucous nodule may at times produce alarming and serious hemorrhage. Tumors of various sizes and location act differently and the chain of remote symptoms may be legion. Frank Lynch reported a series of 376 cases in which one-third of the total number presented hemorrhage as the principal symptom; one-third had symptoms of pain or pressure or both, and one-third had no symptoms whatever. They ranged in size from 1 cm. upwards. Alsobrook of New Orleans, reporting 1,000 cases in the Negro race, noted 59.8 per cent of these patients complained of pain as the principal symptom, 32.1 complained of leukorrhea and 6.1 per cent of bleeding. This variation is typical of reports from different series of cases and it is evident that in those tumors that do cause symptoms no single thing is constant. A cross-section of opinions gives the following group of symptoms in order of importance and frequency:

1. Hemorrhage, which is more common in the submucous type.
2. Leukorrhea.
3. Pain in the lower abdomen.

4. Pressure symptoms referable to bladder or rectum.

5. Sterility in about 50% of cases.

6. Interference with labor (about 4 in 1,000), and interference in the puerperium.

7. Rarely, interference with coitus.

There is a chain of less constant symptoms due for the most part to complications and sequelae. To this group belong secondary anemias, heart disease in 20 to 40%, indigestion, constipation, nervousness, retention of urine, cystitis, pyelitis, and that complex of acute manifestations found at the onset of degenerative processes. An alarming symptom to keep in mind is the occasional intra-abdominal rupture of large veins on the tumor surface with resultant serious hemorrhage.

In the diagnosis of fibroid tumors a careful history is equally important as in more obscure types of pathology. While the average case of uncomplicated myoma of reasonably large proportions is readily diagnosed by the simple expedient of bimanual examination there are numerous pitfalls to be avoided. The history as to rapidity of growth and occurrence of symptoms cannot be omitted where differentiation from other pelvic disorders is necessary. The typical fibroid is discrete and on palpation presents itself as a smooth semi-elastic mass usually freely movable in the abdominal cavity. Difficulty arises with the small tumors centrifugally placed, or in the lower segment, also those associated with adnexal pathology. I have made the mistake of diagnosing ovarian cysts with thick walls as fibroids, a common error in differential diagnosis. The problem of distinguishing normal pregnancy has virtually been solved by the use of x-ray and the Ascheim-Zondek reaction which has proved so efficient. A sudden beginning of rapid growth in a formerly quiet tumor means the onset of degeneration. Polak made the statement that a diagnosis of circulatory degeneration and necrosis in a fibroma can be made from the blood picture alone which shows a high percentage hemoglobin and high red-cell count in comparison to the cachexia and degree of anemia present. Right-sided pelvic pain from a fibroid may be diagnosed as acute appendicitis unless a vaginal examination is done in any suspected case.

Pathology and Degenerations

New tumors do not originate after the menopause; there are none on record before puberty and very few before the age of 19 years. Macroscopically they are smooth, firm, semi-elastic masses of varying sizes attached to the uterus. The majority originate in the upper half of the uterus and are all interstitial in the beginning, their final location depending on their tendency to grow toward the uterine cavity or its periphery, progress being along the line of least resistance. Microscopically they are bundles or knots held together by dense connective tissue (globular type), or a uniform network of fibre bundles held together in no definite arrangement (fascicular type).

To fibroids many things may happen in the form of degenerations, most common of which are:

1. Fibroid degeneration.
2. Hyaline degeneration.
3. Red degeneration.
4. Malignant degeneration (from 2 to 4%).
5. Hemangiomatous, lymphangiomatous or telangiectatic degeneration.
6. Calcification.
7. Fatty degeneration.
8. Necrosis and suppuration.
9. Cyst formation.

The clinical significance of these changes lies in the difficulty they offer in making a definite diagnosis, the large group of secondary symptoms they are responsible for and in being an influence in selecting the proper form of treatment in an individual case.

Treatment

A large proportion of fibroid tumors never produce any symptoms and therefore do not demand any treatment at all. The presence in the abdomen of a palpable tumor as such does not necessarily indicate operation or other form of therapy but all such cases should be catalogued for observation and carefully watched from time to time for developments. When the occasion arises the accepted forms of treatment fall into two groups: namely, irradiation by x-ray or radium and surgery by means of supra-vaginal or total hysterectomy. Our series of cases has been chiefly concerned with the surgical.

The choice of treatment for the individual case depends upon:

1. Age of patient.

2. Physical condition, which determines operability.

3. Local symptoms present, and complications.

4. Size of tumor.

5. Past history as pertains to pelvic inflammation.

6. Economic conditions of patient and availability of special equipment.

The ultimate objectives of any form of treatment are the arrest of hemorrhage, the removal of the tumor or the checking of its growth, conservation of tissues and their functions with lowest possible mortality risk. Thus each case becomes a rule unto itself.

The majority of writers are agreed as to the indications and contraindications for the several methods and their selection or treatment for the case at hand depends upon their personal preference and former experience.

Radium treatment is useful in:

1. Malignancies or strong tendencies toward malignancy of cervix.

2. Inoperable tumors.

3. Continued or recurrent bleeding following myomectomy.

4. Temporary hemostasis in preoperative preparation.

5. Small, bleeding tumors.

6. Cases where operation is refused.

Radium is contraindicated in:

1. Very large tumors. (Authors vary in expressing a size limit, the opinions varying from that of three to six months' pregnancy).

2. Rapidly growing tumors, which usually mean presence of a degenerative process.

3. Pressure symptoms or painful tumors.

4. Pedunculated growths of all kinds.

5. Child bearing age.

6. Profound anemia or very nervous patients.

7. Presence of adnexal tumors or pelvic inflammation.

8. Cases of radiophobia.

X-ray is likewise applicable to small tumors and is a valuable adjunct to radium treatment. It has a great field of usefulness in temporary hemostasis and relief of pressure symptoms preparatory to radium treatment or surgery. It does not disable the patient, nor cause any caustic action of the endometrium and is not contraindicated in cases with history of previous pelvic inflammation.

The greatest advantage of irradiation is in the mortality rate which is practically nil except for an occasional death following preliminary curettage for radium application. Unfortunately, a number of patients have to return for additional treatment, sometimes more than once, and a few must eventually have surgery. Also sufficient irradiation to destroy the tumor usually causes a menopause. The treatment is about 95% efficient.

Operative surgery is applicable to all cases of uterine fibroids except those definitely inoperable because of constitutional disease or malignancy. There is probably no field of surgery that produces more gratifying results than that embracing fibroid tumors. Surgery is, after all, probably the most conservative form of treatment for the reason that operation at once permits complete removal of the tumor and its complications with conservation of tissue, and allows opportunity for an exploration of adjacent organs.

Supravaginal hysterectomy remains the operation of choice with many surgeons for all cases because of its greater ease of performance than myomectomy, and its total removal of the tumor with no likelihood of recurrence. Hysterectomy should be preferred to myomectomy in all cases at the end or past the child-bearing period and in younger women when the size of the tumor is such that an insufficient amount of the uterus could be preserved to permit of proper function, and in precancerous conditions. Whenever it is possible in such cases, healthy ovarian tissues should be conserved. In precancerous conditions or those cases with large badly diseased cervices, total hysterectomy is the method of choice. Percy of Chicago practices conical excision of all cervices by electric cutting current preliminary to supra-vaginal hysterectomy.

The earliest operations upon fibroid tumors were in reality myomectomies but were limited to submucous and occasionally interstitial tumors. In recent years myomectomy seems to have gained favor in selected cases, and justly so. There is no other procedure that serves the intended purpose of removing the tumorous growths,—or several tumorous growths,—and at the same time conserving the tissues, as this. This means that a young woman, potentially fertile does not become denied the sacred privi-

lege of motherhood because of the presence of a small fibroid. Many uteri have been needlessly sacrificed by hysterectomy done on patients with no other indication for operation than a relatively small and palpable tumor. I do not mean to say that this is common practice, but in such instances an otherwise usable organ might have been restored by more careful consideration of the possibilities and applicability of simple enucleation. Myomectomy is frequently condemned for its reputed higher mortality rate—usually mentioned as 5%. Yet a recent report from the Mayo Clinic lists a series of 157 consecutive myomectomies done with but one death resulting. Recent statistics reveal information that the mortality in carefully done myomectomy is no higher than that for hysterectomy.

Except as previously mentioned, where insufficient tissue can be preserved, myomectomy should be considered for all cases of solitary tumors in women under forty years of age. Multiplicity is not a contraindication, for as many as thirty small tumors have been removed at one operation. The procedure offers at least a 25% chance for subsequent pregnancy. The pre-disposition to abortions is not as strong as previously supposed. From 1904 to 1922 Cotte collected 85 cases of myomectomy done at various stages of pregnancy of which number 65 went on to normal delivery term.

Myomectomy is suited for performance during pregnancy when necessary to remove a tumor that is likely to prevent or seriously interfere with delivery, also for removal of large tumors of the fundus that interfere with natural growth of the pregnant uterus.

Treatment of fibroids during pregnancy is not indicated unless the above mentioned conditions prevail, or in the event of torsion of a pedicle, or in the presence of degenerations that cause symptoms. The choice of treatment in such situations lies between myomectomy or Caesarean section followed by hysterectomy. The chief difficulty usually arises in the puerperium when fibroids may seriously interfere with normal involution of the uterus or have taken on degenerative processes. Under such circumstances hysterectomy is indicated.

For all surgical procedures the mortality rate ranges between 1 and 2%. Our series of cases which dates from 1929 shows a mortality rate of 1.7%.

Summary

1. Fibroid tumors of the uterus comprise a common type of pathology of interest to all branches of medicine.

2. Etiology of fibroids is still unknown.

3. The incidence is higher in colored women than white, being about 4 to 1.

4. Fibroids present no common, definitely constant symptom and many grow to large proportions without producing any symptoms at all.

5. With present methods of precision the differential diagnosis is simplified.

6. Surgical treatment is the most conservative and practical when considering all types of cases.

7. Myomectomy is to be preferred in all cases of solitary tumors found in women in the childbearing age.

DISCUSSION

Dr. Leigh F. Robinson, Ft. Lauderdale:

Dr. Netto has covered his subject in an admirable manner and so fully that there is little left to discuss. I would, however, like to enlarge on one or two points.

The question of irradiation versus operation depends largely on the type of tumors. Radium will not cure subperitoneal tumors and will do harm to the submucous pedunculated forms. To get the desired results there should be a diffuse circulation from the intramural walls. Even when a decision has been made to employ radium one should have an understanding with the patient that after the anesthetic has been administered and preliminary exploration of the uterus has been made that only then can we absolutely say that radium is indicated. Also in the event that it should be found contraindicated, the surgeon should have the permission of the patient to perform a hysterectomy. When radium is indicated we have the most valuable agent used in this type of therapy, but as Bland has pointed out, it is not generally appreciated that of all the agents used it is probably the most dangerous. Today with so many commercial institutions renting radium with widespread advertising campaigns this valuable agent is too often placed in the hands of physicians with very little experience. Complications from the use of radium cannot be avoided even in the most expert hands, but most of the complications happen largely with those who should not use the remedy, for in-

stance, the general practitioner, the surgeon or gynecologist who only occasionally make use of it.

The decision of whether a myomectomy or a hysterectomy shall be performed cannot be made until the abdomen is open. As has been pointed out by the essayist, myomectomy should be considered for all cases of women under forty. There is nothing that makes your patient more happy than to learn that she is not unsexed following an operation. Rarely will the surgeon be criticized if after a few years the patient finds that another fibroid has developed and she must undergo another operation. The question of recurrence after myomectomy will, however, in many cases influence the patient's attitude. Bonny some years ago reported a series of cases with no recurrences, but as Giles has pointed out only after every seedling fibroid has been removed can we be sure of no recurrence.

Dr. Lloyd J. Netto, W. Palm Beach (concluding):

I wish to thank Dr. Robinson for his generous discussion of the paper. I think this question of the treatment of fibroid is many times considered too lightly. Of course those of us from the south see most of our cases among the Negro race and charity service in the hospitals. And most of the time they cannot be given the same consideration as private patients are. This also influences the use of radium and x-ray, which I feel are very valuable adjuncts in the treatment. The x-ray is particularly valuable for the cessation of a hemorrhage because it does not cause any deaths, is not contraindicated in cases with previous pelvic inflammation, and does not cause any caustic action on the endometrium. In the use of radium (not from personal experience but from the literature) the main thing is the proper selection of cases and the absolutely accurate estimation of dosage in the hands of an expert.

I realize that quite a lot might be said about fibroid tumors, and that it is a subject that should be considered as most important because it comes to all of us almost every day, from the general practitioner on up. The general practitioner is the man who sees these cases first and oftentimes is puzzled at some remote symptom that may be found to have its cause in a little fibroid tumor if trouble is taken to do a very thorough vaginal examination, a bimanual examination.

THE SIGNIFICANCE OF TUBERCULIN REACTION IN TUBERCULOSIS CONTROL*

W. A. Claxton, M.D.,
(Tuberculosis Clinician, State Board of Health)
Jacksonville.

Tuberculosis is a widespread disease. No one knows how much tuberculosis there is in Florida. Our physicians reach a number of families and cases. Our public health nurses discover a few. Our clinics bring out some more but even this combination of effort of doctor, nurse and public health worker misses a great many or at least discovers them when they are in the far advanced stages of the disease. We know that we had 1035 deaths from tuberculosis in 1933 and probably have 5,000 cases in the state.

In Framingham, New York, where several years were spent in intensive antituberculosis activity, it was found that a careful house to house survey discovered nine times as many cases of tuberculosis as had been previously known to the public health officials. It can therefore be understood that any program that has as its aim the discovery of tuberculosis and the prevention of its spread must be very thorough and must reach every home in the community.

A study of the history of tuberculosis teaches us that the discovery of the frank case of the disease, that is, the person who comes to the doctor with a cough, a little fever, loss of weight, a feeling of perpetual tiredness and perhaps night sweats, is not going to get at the bottom of the tuberculosis problem. The way to control tuberculosis is to go where tuberculosis is or has been. The fruitful search is the search made among contacts. The place to find contacts is in the home and the time to find them is in childhood.

We need a comprehensive and continuous program which will go on month after month and year after year. We should keep complete and easily available records of every death from tuberculosis, every person ill with tuberculosis and every child infected with tuberculosis, and should follow these cases year after year and know the condition of the health at all times. This necessarily involves a close concentration of effort and a full-hearted interchange of information between the practicing physician, the public health nurse and the State Board of Health.

*Read before the annual meeting of the Florida Tuberculosis and Health Association, Jacksonville, April 30, 1934.

It also necessitates an adequate staff of state and county nurses and doctors.

Twenty years ago, the target at which we aimed was the "early case" and much was said and written about the best methods of discovering this early case. In fact, our criteria of diagnosis became so refined and meticulous that we found, or thought we found, tuberculosis on evidence so slight that in many instances, the disease was not present at all.

As we continued to study the problem of control, we discovered that our future responsibility was towards the contacts, that is, the children living in the house with the active germ-spreading adult. Susceptible children, especially, easily become infected and we realized that these infected children would constitute the next crop of tuberculosis suspects. We discovered that tuberculosis is found ten times as often in families where there is a history of contact as in those families where there is no history of contact. The family circle that the child is born into, lives and crawls in and is fondled and kissed in, is the chief spreading place of tuberculosis. We must, therefore, aim at the contacts.

Early tuberculosis does not find itself but has to be hunted out. To do this, we must have access to a group of individuals that can give us clues which will lead us to tuberculosis cases. The school is the natural, normal place where we can hope for success in this direction.

For several years, a method has been in operation, which will pick out children who are infected and direct our attention to homes where there may be an adult with tuberculosis. This method is known as the tuberculin test. The test is a simple, harmless procedure, which consists of the injection of a very minute quantity of diluted tuberculin into the skin of the forearm. At the end of 48 hours, a reaction appears in a certain percentage of persons which indicates that they are infected with tubercle bacilli. This evidence of infection does not mean that all these children have tuberculosis as a disease, because the infection may be slight and may be entirely encapsuled or healed by calcification. A physical examination of these children usually will not reveal any signs of tuberculosis in the chest.

To separate these infected children who have healed tuberculosis from those who have active tuberculosis and therefore need treatment, a further procedure is necessary. We must take x-ray films of the chest. Unfortunately, in Florida, we have not had facilities for making x-ray examinations on many of the school children whom we have tested by tuberculin, so I will refer to some figures that are the result of Dr. Arnold S. Anderson's work in Minnesota. (Dr. Anderson is with us today and will speak on this morning's program). Taking one survey made in 1932-33, we have the following record:

20,931 children were tested.
3,139, or 15%, gave a positive reaction.
582, or 2.8%, showed childhood tuberculosis.
42 showed adult type of tuberculosis.
380 old sources of tuberculosis infection were found.
34 new sources of infection were discovered.

This infection rate of 15 per cent is similar to that found in Florida, where in 9471 tuberculin tests on school children, there were found 14.8 per cent infected, (11.8 per cent white and 18.4 per cent colored.)

Analysis of a survey of this kind brings out several points of interest. First, the small number of adult type cases—42 in 21,000. This shows that adult type tuberculosis is rare in school children. Second, this tuberculin testing survey allows us to concentrate our efforts on the 15 per cent infected children and forget about the 85 per cent non-infected group. The third point of importance is that the vast majority of these 582 cases of childhood tuberculosis would not have been discovered had it not been for the routine testing in the schools, because such children have few or no signs of the disease that can be demonstrated without the x-ray. The fourth point of importance is that 414 sources of infection were found and the spreaders of tuberculosis placed under the supervision of the physician and public health nurse so that they can either be removed to a sanatorium or taught, in the home, the importance of a mode of living which will prevent further infections among the contacts.

In our tuberculosis program, we rely on the family physician. He is the center around which all our control measures must function. The treatment and cure of tuberculosis is not to be brought about by drugs and any doctor who claims that he can cure tuberculosis by drugs or injections is misleading his patient. Rest and a sensible diet together with sanitary surroundings and fresh air are the only cures for tuberculosis. The family physician is the man to go to for advice. If he needs help from someone who has made a special study of this disease, he will arrange for consultation.

If tuberculosis is to be conquered, there must be missionary work, something must be done by

those who see a need for it, for those who require the help but do not see any need for it. We must interest parents in the importance of having their children tuberculin tested. We must have some place to put tuberculosis patients where they can get well and where the children can be protected from continuous infection. Under the existing economic circumstances, the obvious place is a state sanatorium. In the meantime, we must work in the field to discover and teach tuberculosis patients to prevent the infection of their children and to discover children that need treatment.

Six months' treatment of a boy or girl with childhood type infection is as beneficial as two years' treatment of the same person after he has developed adult type infection twenty years later.

THE TREATMENT OF PULMONARY TUBERCULOSIS*

ARNOLD S. ANDERSON, M.D.,
St. Petersburg.

The treatment of pulmonary tuberculosis has passed through many stages. There is perhaps no other affliction that has been the object of so many therapeutic missiles as this disease.

At the time of Hippocrates much stress was placed on the importance of a diet full of rich, easily digested food. Fresh milk was particularly advocated and human milk was preferred to cow's milk. Breast feeding was therefore frequently prescribed for those afflicted. This was advocated because of the belief that air coming in contact with the milk made it less digestible. Mountain climate was also considered effective.

This was to a great extent the Greek form of treatment. The Romans made it more complicated. Here we find that the liver of the wolf in wine, the lard of a thin sow fed on herbs, the smoke from the dried tongue of a cow, when the animal is in green pasture, hung over a sugar cane, were considered valuable for the cure of consumption. A drink made from the shavings of the hoof of the ox, scalded with honey, was a very good remedy. The use of ashes from the hoofs of deer was effective in hemoptysis. Medical history abounds with thousands of such remedies used with great sincerity and high hopes.

The treatment of tuberculosis was much the same for many centuries. During the eighteenth century great reliance was placed on various forms of elimination. Emetics and purgatives were essential. Bleeding was frequently resorted to. The popularity of these forms of treatment is well shown by a verse written by Dr. I. Lettsom, a physician of the eighteenth century. He wrote,

> "When patients sick to me apply,
> I physics, bleeds and sweats 'em,
> If after that they choose to die,
> What's that to me?—I. Lettsom."

The nineteenth century brought a ray of hope. In 1846 Dr. George Bodington of England threw physics to the dogs and insisted on a regime of good food and fresh air for the tuberculous and no purging. He established an institution for their care but his ideas were so radically different from the generally accepted ones of the day that he failed. His sanatorium was converted into an insane hospital.

Dr. Herman Brehmer of Germany opened the first successful sanatorium in 1853. His patient and pupil, Dr. Peter Dettweiler, however, was the first to recognize the real significance of rest for the tuberculous and so to him goes the title "The Father of the Rest Treatment." Dr. Edward Trudeau pioneered this work in the United States and it was greatly to his wisdom and persistent efforts that the value of rest for the tuberculous became recognized in the U. S.

The combination of rest, good food and fresh air is the tripod upon which the treatment of tuberculosis has rested for many years. Each has passed through a transition period until the rest, food and air as given today, is quite different from that of a few years ago.

During the seventeenth and eighteenth centuries night air was considered dangerous and so windows were kept closed both for the sick and well in order to prevent the harmful influence of night air to enter the rooms. This was followed by the opposite extreme in the treatment of the tuberculous and we then witnessed a fresh air orgy in which, winter or summer, the windows must be wide open at any cost. Our sanatoria were built to expose patients as much as possible to the fresh air and protect them as little as possible. This led to the common remark among patients, that "the cure was worse than the disease." The last few years have brought a marked change in attitude regarding the value of the open window. We now advise a comfortable temperature with proper ventilation and humidity as the desired end, rather than a wholesale application of air regardless of its tempera-

*Presented before the Pinellas County Medical Society on May 4th, 1934.

ture. Our modern sanatoria are built with this in view, being more like hospitals than open-air institutions.

As we look back at the priceless value that we placed on cold air, it does seem a strange paradox how, in one instance we would defend the wide-open window in the middle of a severe winter, and in the next breath we would advise the patient to take advantage of the warm, equable climate of the south. Present day opinion favors the view that climate is of minor importance in the treatment of tuberculosis. Comfort rather than climate is the important factor and if that can be obtained in the north as well as in the south, and that I frequently question, then change is unwarranted. Regardless of the above, however, we must always remember that the proper application of rest is the thing of paramount importance.

The value of good food in the treatment of tuberculosis is self-evident. The kind of a diet to follow, however, has caused much argument. A number of years ago when forced feeding was in vogue, many cases are on record where patients consumed as many as five thousand to seven thousand calories a day. May the poor patients forgive us for that. We now know, of course, that the ingestion of such terrific amounts is a gross extravagance and that it works a hardship on both the gastro-intestinal and respiratory tissues. It has been brought out well that an excessive protein diet causes an increase in the respiratory exchange and so tends to interfere with the best pulmonary rest. Today we feel that a daily diet containing twenty-five hundred to three thousand calories, having in it about sixty to ninety grams of protein and well supplied with vitamins and minerals, is the one of choice for the tuberculous. No raw eggs are required.

Before leaving the subject of diet, mention must be made of the Sauerbruch-Gerson diet in the treatment of tuberculosis. First used successfully in lupus cases, it has lately been applied to pulmonary tuberculosis. Dr. Edgar Mayer of Saranac Lake has tried it on a number of cases with some success. Its full value, however, is still to be established. The essentials of this diet consists of a low sodium chloride and a high vitamin and mineral content. Its preparation is quite detailed and therefore not practical enough to make it popular.

We approach the rest treatment of tuberculosis with a considerable amount of reverence. This form of therapy has also changed greatly since it was first advocated by Peter Dettweiler. When Dr. Trudeau first applied it to himself, rest consisted of sitting with his trusty rifle in the pathway of wild game, waiting for the opportunity of exercising his marksmanship. Trudeau soon observed, however, that with increased physical rest came decreased cough and temperature and so he soon forsook the woods for the bed and became a staunch advocate of the rest treatment. Since Trudeau's time, the tendency has been to increase the amount and length of bed stay for the tuberculous.

Rest may be divided into two groups: (1) general, and (2) local. By general rest we mean that freedom from strain best obtained by means of the bed. In the active case it should be absolute, not even allowing bath room privileges. It should be continued until the lesion has become stationary as shown by symptoms and by physical x-ray and laboratory examinations. Of course each patient must be treated on his own merits but a safe, general rule to follow for the best results from bed rest is to keep the patient in bed for as long a period after his toxic symptoms have subsided as it required to produce a subsidence of them. In other words, if two months were necessary to clear up the symptoms, two months more of absolute bed rest should be instituted before allowing the patient to be up. The process of bringing the patient to the stage of exercise—that is, walking—must be a very gradual one and involves a period of weeks.

By local rest we mean "collapse treatment" of the affected lung. The three principal methods are: (1) artificial pneumothorax; (2) operations on the phrenic nerve; (3) extrapleural thoracoplasty. Each has its own place.

There is no doubt as to the importance of collapse treatment in pulmonary tuberculosis. It has provided us with a means of combating the disease that has saved thousands of sufferers and brought them back to a gainful life, which otherwise would have been impossible. It has shortened the period of convalescence and relieved symptoms that previously were intractable. Wonderful as these measures have been, they have nevertheless been accompanied by certain dangers. With the increasing popularity of pneumothorax and phrenic nerve operations, there is, of course, the tendency toward their indiscriminate use—a neglect in the proper selection of cases. There is also the danger of forgetting the value of bed rest and placing undue hopes on local rest of the lung. We must remember that bed rest, besides

having a beneficial effect upon the local lesion, also has a salutory influence on the body as a whole. In treating tuberculosis, we must consider the whole individual rather than a specialized part. And so we must bear these points in mind if we hope to gain the best results.

The indications for the induction of artificial pneumothorax, are the following:

1. Small or extensive exudative unilateral lesions that continue to progress under conservative treatment.

2. Unilateral cavitation with a serviceable opposite lung, that is, one with little or no active disease present.

3. Patients with profuse or small repeated hemoptysis where the lesion is limited to one side.

4. Frequently pneumothorax is employed bilaterally in cases that show a tendency to progress under bed rest—a partial collapse on each side is often very valuable.

5. Patients who are denied the benefits of a long sanatorium stay and who require collapse treatment to speed the healing of the local lesion as fast as possible.

Phrenic nerve operation is done:

1. In those cases where artificial pneumothorax fails because of extensive adhesions.

2. To aid an artificial pneumothorax in gaining additional collapse.

3. To permit of longer intervals between pneumothorax refills.

4. In preparation for a thoracoplasty to give more complete immobilization to the affected lung.

Phrenic operations consist of the following:

1. Crushing of the nerve.

2. Alcohol injections.

3. Complete removal of the nerve (phrenic exereses.)

This last is now the most commonly practiced procedure because of the fact that about thirty per cent of phrenic nerves carry accessory branches which remain unaffected by the use of the aforementioned operations.

With interruption of the phrenic nerve, the paralyzed diaphragm rises into the thoracic cage and causes about a thirty per cent reduction of lung volume. It also produces a loss of tonicity of the pulmonary tissue with a resultant partial immobilization. These factors frequently favor the healing of an exudative lesion and in many instances aid in the closing of cavities.

Extrapleural thoracoplasty is reserved for those chronic fibroid cases that failed to benefit from pneumothorax or phrenic nerve evulsion. It is not indicated in active exudative lesions that show a rapid tendency to progress. The type best suited for this operation is one with extensive unilateral fibroid disease with cavitation, and positive sputum, but whose general condition is good enough to make him a favorable surgical risk. There are many of these patients who are saved from premature death and returned to a gainful life, through thoracoplasty. About five per cent of patients admitted to a sanatorium are suitable for this operation.

The use of heliotherapy for pulmonary tuberculosis has not been generally practiced. Its value is still a subject of argument. In view, however, of its real worth in extra-pulmonary tuberculosis, it is difficult to believe that it does not hold some definite virtue for lung lesions. It has been used by some investigators with more or less success in the chronic fibroid type of disease. It would seem advisable in this type of case if for no other reason than for its tonic effect on the body as a whole.

This review of the treatment of pulmonary tuberculosis would not be complete without mention of the need for treating non-tuberculous complications as they arise in the patient. Infected tonsils, teeth, sinuses, etc., are sometimes burdens to the tuberculous body, that must be corrected before improvement sets in. Here we must also consider the necessity of putting the patient in the best possible frame of mind for the long battle that he has before him. The correct mental attitude goes far in making the fight a success. It is here that the art, rather than the science of medicine, avails one and we are reminded of the truthfulness of Charcot's favorite maxim (from Coleridge)—"the best inspirer of hope is the best physician." Dr. Trudeau insisted that the first step in the treatment of tuberculosis after the diagnosis was made, was an attitude of acquiescence on the part of the patient—a calm acceptance of his disease. The physician, by explaining the favorable aspects of the disease, its curability as well as its compensations (for they are present), can do much to bring about this desired mental attitude.

In conclusion let us state that the treatment of active pulmonary tuberculosis consists in the utilization of those measures that promote physical and mental rest and peace, general and local restriction of movement, proper nutrition, and good medical supervision.

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REGARDING NEXT YEAR'S PROGRAM

This year the Committee on Scientific Work is trying a new plan for the State Meeting to be held in Ocala.

In the first place, the members of this Committee feel that heretofore too little time has been allowed for discussion of papers. The program has been so full that it has usually been necessary to hurry through. To obviate this they are having fewer papers. These, it is hoped, will be of great interest to all members of the Association and will provoke much freer and more prolonged discussion. Oftentimes the discussion of a paper is of as much, if not more, value to the membership than the paper itself. Therefore, active and full discussion is to be encouraged.

It has been the custom in the past for the men who desire a place on the program to send in requests to the Committee. This year the Committee feels that the reverse should be true. It is an honor to appear on the State program and this honor should go to men whose work merit it.

Your Committee on Scientific Work is asking each County Society Secretary to send the name of the author and the title of the best paper which was read before his Society during the past year. From these the papers that seem the best suited to the needs of the State program will be chosen by the Committee and an invitation sent to the essayist to read it before the Association.

The fullest co-operation of the membership is asked and it is hoped that the program will be of great benefit to all who attend.

SECOND GRADUATE SHORT COURSE

Six months have elapsed since the Second Graduate Short Course for Doctors of Medicine was held in Gainesville. In this period of time, it has been possible for the officers of the Florida Medical Association and the members of the Medical Post-Graduate Course Committee to sound out the medical profession in Florida for its reaction to the course. For the most part it is agreed that the course was beneficial since it presented well-known men with valuable messages. Moreover, the officers and committee feel that the course reached a good percentage of the medical men in the state, inasmuch as, of the 1,671 physicians registered with the State Board of Health, approximately one hundred have attended the course each year. As there were many new registrants for the 1934 session, the attendance for the two years represents approximately 12% of the total number of physicians in the state. Several of the lecturers, who had offered in other states similar courses, which were indifferently received, expressed their surprise and gratification at the interest displayed in Florida. Successful as the courses have been in the past, however, the committee is eager that even more physicians attend future sessions. To stimulate interest, every doctor registered to practice in the state will be contacted by some officer in the State Medical Association before next year's program is presented.

Acting on the suggestions of the men who attended the first course, the committee made a number of changes in the program for the second year. The general plan of the two previous courses will be adhered to in presenting the third next June. The Committee on Medical Post-Graduate Course appreciates suggestions of any nature, which will assist the members in making further improvements. Among the innovations last June were the model miniature laboratory set up by the State Board of Health, the displays of the Florida Tuberculosis and Health Association and the American Society for the Control of Cancer, and the exhibit of the Florida Roentgenological Society with a roentgenologist constantly in attendance. Probably the most popular single feature of this year's course was the practice of having one of the lecturers preside at each luncheon meeting, answering questions previously put to him by men taking the course.

Echoes of Florida's experiment with the graduate courses for doctors of medicine have penetrated the entire country. Numerous requests

have been received for information concerning their organization, financing, management, and reception, even from as far away as Idaho. To those leaders who inquire with some trepidation whether or not the vast labor of planning and putting over a course of this nature is worthwhile, the Committee is prone to reply with a quotation from a letter from Dr. Chevalier Jackson, one of the lecturers who gave their services, written upon his return home after the 1934 Short Course:

". . . So far as I was able to observe the courses were a great success. It seems to me that it is the kind of movement that should be carried out all over the country. Judging by my own personal experience as a listener, not as a teacher, there is an inspiration absorbed at this kind of meeting that equals in value the information obtained. I always come home inspired for more and better work. . . ."

NEW RECORDS FOR TUBERCULOSIS SANATORIA

For the first time it is now possible for tuberculosis sanatoria to keep uniform and complete records of all material facts about their patients, available at all times for instant consultation. This important improvement in health bookkeeping is a result of two years' work done by a committee of the American Sanatorium Association, assisted in a secretarial capacity by members of the staff of the National Tuberculosis Association. The 23 new forms which have been prepared are obtainable from the Livingston Press, Livingston, N. Y.

Formerly it was often necessary, when information of a consecutive or cumulative nature was needed, to expend considerable time and effort to collect and arrange pertinent facts from records made at different times, and reposing in various forms which were kept primarily for other reasons than the one which might now be in mind. The new system has the added advantage in rendering available, as a matter of routine, facts which serve to satisfy statistical needs from a national viewpoint.

Some of the forms are merely improvements over existing ones; others make an original contribution. Among the latter are these pertaining respectively to (a) nose, throat, ear, eye and teeth; (b) pneumothorax; (c) operations; (d) tuberculous empyema; (e) statistical summary on discharge.

INJECTION TREATMENT OF HERNIA (Pina-Mestre)

A letter from the Pina-Mestre Clinics, Inc., Orlando, has been circulated among doctors in Florida. It reads as follows:

"We are writing this letter to a selected list of medical men over the State of Florida whom, we believe, are interested in the progress of medicine generally, to acquaint them with the Injection Treatment of Hernia (Pina-Mestre). This method has been used in the State of Florida for some time by some of the leading medical men of the State with much success.

"Within the last five years there has been treated more than 16,000 cases with Pina-Mestre's Hernial Solution 'without a bobble'.

"If you are interested in knowing more about this advance in Medical Science, we shall be glad to send you technic and other literature on request."

A report of this product by the Council on Pharmacy and Chemistry of the American Medical Association appeared in the February 1, 1930, Journal of the American Medical Association, page 339, under the heading "Hernial (Inyecciones Proliferantes Obturadoras del Dr. E. Pina Mestre) Not Acceptable for N.N.R."

The following quotations are from that report:

"The product 'Inyecciones Proliferantes Obturadoras', stated to be manufactured by Dr. E. Pina Mestre of Barcelona, Spain, was presented to the Council for consideration under the name 'Hernial' by the Vincent Ruiz Company, New York. According to the information submitted by this firm, 'Each ampule contains approximately 98% alcohol, and the balance consists of the following ingredients expressed in percentages: 25% Krameria, 16% Catechu, 15% Rosa Canina, 15% Rosa Centifolia, 14% Vaccinium Myrtillus, 15% Monesia'. No statement of composition appears on the submitted trade package, on which the product is called 'Inyecciones Proliferantes Obturadoras' and not 'Hernial'. * * *

"The Council declared 'Hernial' (Inyecciones Proliferantes Obturadoras del Dr. E. Pina Mestre) unacceptable for New and Nonofficial Remedies because it is an unscientific, indefinite and complex mixture of astringent drugs proposed for use in the treatment of hernia, for which unwarranted claims are advanced and the use of which is not warranted by the available evidence but, on the contrary, is considered to be dangerous."

RADIO BROADCAST, 1933-34

The following broadcast was arranged by the Public Relations Committee of the Florida Medical Association and given over station WRUF, Gaineville:

THE ORGANIZATION OF THE HUMAN BODY*

T. Z. Cason, M.D.,
Jacksonville.

The interrelation of the composite body and the interdependence of its members were recognized clearly by Paul in his First Epistle to the Corinthians when he wrote:

"Why, even the body consists not of one member but of many. . . . If the ear were to say, 'Because I am not the eye, I do not belong to the body,' that does not make it no part of the body. If the body were all eye, where would the hearing be? If the body were all ear, where would smell be? . . . As it is, there are many members and one body. The eye cannot say to the hand, 'I have no need of you,' nor again the head to the feet, 'I have no need of you.' Quite the contrary. . . . Yes, God has tempered the body together, . . . so that there may be no disunion in the body, but that the various members should have a common concern for one another." (I Cor. xii:14-25. Moffatt translation.)

This composite body, so ingeniously tempered that "if one member suffers, all the members share its suffering," as Paul well knew, is composed of tissue formed from cells of which there are four main types—epithelial, muscular, nervous, and connective. It is an established fact that the unit of all the kinds of body tissue is the single cell which is modified in keeping with the special function of the particular organ or tissue system which, in the aggregate, it comprises.

The skeletal system of the body forms its framework and provides the support around which is woven the muscular system. The tissue of this system contracts when stimulated and motion results. Through the vascular and circulatory systems all the fluids of the body are carried. There are also the respiratory, the alimentary, the excretory and the reproductive systems, the functions of which are well known. Through the various tissues of the body the nervous system forms a network which directs the coordination and control of all the working parts of the body and in which sensation and intelligence center. It is the proper assembling of the vast number of cells of the tissues and the resulting coordination between the systems which they form that make the integrated whole a healthy human being.

The single cell or fertilized ovum from the complicated division of which the human being develops, contains many minute particles called genes. These genes, one set or chain from each parent, are paired in the new organism and it is the manner of their union which determines the factor of inheritance in the development of the individual. They hold the secret of physical characteristics and of many mental traits.

Prenatal influences include physical environment, food, and medical care. They do not include the superstition that a mother may mark her child for to do so is impossible because there is no direct nerve connection between mother and child. Not biologically, not through the germ plasm, but in an environmental way—the way the mother lives—is prenatal influence effective.

Environment vies with heredity in importance as a developmental factor; it influences and indeed may even alter inherited tendencies. In infancy regularity is the keynote in child development. The establishment and maintenance of routine in a matter-of-fact way is very important, for the repetition of a single nerve response means closer and closer interlacing. That is learning, and forgetting is simply unused responses falling back or apart. In the conditioning process of the very early stage of development lies the secret of habits of skill, emotion, intellect, moral attitudes and other attributes of the organized human body. The significance of the early training and surroundings of the preschool age and of elementary education can hardly be overemphasized.

The material substances called body tissues, influenced profoundly by the pattern of the inherited genes and beaten upon by a complex environment, find in the nervous system the basis of adjustment to the external and internal conditions of life. Through it the body not only acquires but expresses its unity. This system consists of the brain, the spinal cord and the nerve trunks. Each nerve cell or neuron has a body and long slender arms, one called an axon, the others dendrites. These arms are "one-way" lines. The dendrites transmit stimuli to the cell body; the axon carries messages from the cell body. The nerves of sensation, pain, touch and sight are dendrites, carrying messages

*Radio broadcast delivered under auspices of Florida Medical Association over Station WRUF, Gainesville, March 4, 1934.

to the brain cells while the motor nerves, carrying messages from the brain to the muscles, are bundles of axons. The brain itself has something like twelve thousand million nerve cells, millions of them packed closely together to form the grey matter, the remainder massed into bundles, ropes and cables which serve as association or projection fibres. Because the nervous system is what it is, a miscellaneous bundle of more or less conflicting response-tendencies becomes an individual—an integrated person, for the "mind," generally speaking, is nothing more than the final representation of the function of the organism as a whole.

From its constituent parts the whole emerges into a person—an individual whose delicately wrought and intricate mechanism, ingeniously articulated and coordinated, functions in direct ratio to its proper set-up. It is at the outset committed to but two objectives—self-preservation and propagation of its species. To attain these ends it is prepared not only to function and to reproduce but to fight the trillions of minute organisms which are man's greatest enemy and to adapt itself to a wide range of circumstances and conditions.

In the blood serum along with the many millions of red blood cells, there float other millions of white blood cells which form the defense army of the body. These cells, always on duty, multiply on demand, rush to the point of attack and, concentrating there, actually devour those invading organisms which are inimical to the health of the body. Fever is but a fighting device, one of the generals which the body uses to aid its army of defense. Artificially elevated temperature has become a recognized specific in certain diseases. The skin is the defense armor of the body and in large measure takes precedence over all other defense agents which the body can command in its unaided efforts to insure its own well-being.

Complementing the fighting ability of the body is its adaptive power. Man cannot tear down, examine and rebuild its intricate mechanism, replacing worn parts with new, as he can the products of his own ingenuity. Both the repair and the replacement processes are often far too complicated for him to fathom, much less supply or instigate. Fortunately, however, the body itself carries on these processes in a marvelous way which far exceeds the ability of man to remedy and build anew his own creations. Every organ of the body is capable of adjustment within a wide range, depending upon the demands that are made upon it. The body not only adapts itself to necessary changes during a repair process but also adjusts itself to those alterations which result from permanent damage. The heart, for example, becomes enlarged as it carries an added burden; the hearing and the sense of touch become more acute as they endeavor to compensate for defective sight.

So well organized is the body that the selective action of its cells makes possible the elimination of drugs by various routes. One drug, x-ray studies show, is discharged through the kidneys. Another, after outlining the gall-bladder so clearly that it is plainly visible on an x-ray film, is excreted through the liver. Still others are eliminated through the intestinal tract and the lungs. So delicately adjusted is the mechanism of the body that the range of its temperature varies but a few degrees; yet a slight variation from the normal range may play havoc with the entire organism, and a marked variation certainly will.

Every organ has a function to perform, definite in degree as well as kind. An alteration in sufficient degree of the function of any of the glands of secretion, whether internal or external, will throw the whole body out of order. Variation of gland secretion, either over or under the normal amount, will disturb the whole organism and, if continued, an appreciable excess or deficiency will result in destruction of the body.

The organized human body is far more than a chemical factory which ceaselessly converts food and air into energy and tissue; it is far more than a saturated solution of nerves which coordinate the many parts of its complex mechanism and cope with the complex environment that surrounds it. All that it is and does is inherent in the whole past history as well as in the present situation of the individual. When as thinking human beings we contemplate not only our physical attributes but also the innumerable attributes which we have inherited and acquired, we awake to the responsibility which is ours in the care of the body. We may indeed say with David of old that we are "fearfully and wonderfully made" and we should, in consequence, not only give the body the respect and admiration which it deserves but also treat it with that care which will prevent maladjustment.

So subtle, so insidious, so far-reaching are the ramifications of disease that only those who are thoroughly trained and experienced and who have

the best possible understanding of the organization of the human body are competent to detect and diagnose the functional and organic disturbances and abnormalities which readily beset the body. Easily thrown out of adjustment, and often with serious consequences, it is not always as easily restored to normal. The process of restoration requires the expert knowledge of the physician trained both to restore and to maintain the normal functions of this masterpiece of living organisms.

DR. FRANK L. FORT HONORED

Edward C. DeSaussure Post No. 9, American Legion, Department of Florida, presents its medal for the most outstanding and distinguished service to the community during the year 1934 to Dr. Frank L. Fort, Orthopedic Surgeon.

Dr. Fort for the past ten years has served the crippled children of the state and of this community first as Orthopedic Surgeon for the state under the State Board of Health, and later in a similar capacity for the North and West Florida District under the enlarged program of the Florida Crippled Children's Commission.

His service through these channels has been out of all proportion to the meagre compensation received, and of a quality and in a spirit that cannot be expressed in terms of money.

Dr. Fort has also given his skill and time unstintedly to Hope Haven and the various hospitals, as well as to numberless cases of crippled children whose parents were financially helpless to provide care.

Because of this service rendered above and beyond the strict call of professional duty, and because this service has been rendered in such a beautiful spirit to these helpless children, and because we believe that the children themselves who have benefited by the skilled hands and sympathetic heart of Dr. Fort would approve this choice—for these reasons, the Legion is proud to give its medal to Dr. Frank L. Fort.

(Signed) E. R. Vaughn,
Post Commander.

FLORIDA PUBLIC HEALTH MEETING

The sixth annual meeting of the Florida Public Health Association was held in Jacksonville, December 3, 4 and 5, at the Mayflower Hotel. The program was of unusual interest and included important papers from a number of leading authorities from various states. The object of the meeting was to get together all persons engaged in public health work for a conference and exchange of ideas.

The meeting was called to order by the president, Dr. J. R. McEachern, who is City Health Officer of Tampa. Dr. McEachern's presidential address will appear in the January number of the Florida Health Notes. During the morning session, a report on "Pulmonary Spirochetosis" was presented by Dr. George Attwood, Health Officer of Waycross, Georgia. Dr. C. C. Applewhite, Surgeon, U. S. Public Health Service, presented a paper on "County Health Units." Dr. Henry Hanson, State Health Officer, then read a paper on "Public Health Progress" and Dr. T. F. Murphy, Chief Statistician for Vital Statistics, Bureau of the Census, Washington, D. C., opened the discussion. The next paper on "Early History of Vaccination against Smallpox" was read by Dr. Victor H. Bassett, City Health Officer of Savannah, Georgia. Dr. C. E. Waller, Assistant Surgeon General, Washington, D. C., read a paper on "Rural Health Service." Dr. Richard P. Strong, Professor of Tropical Medicine, Harvard University, read a paper on "Some Health Problems Regarding Parasitic Diseases transmitted by Insects." Dr. C. D. Hopkins, City Health Department, Tampa, read a paper on "Epidemiology." Dr. George N. MacDonell, City Health Officer, Miami, read a paper on "Dengue in Miami," followed by a paper from Dr. T. H. D. Griffitts, Director of Malaria Control Studies, on "Significance of Dengue Epidemic." Horatio Newton Parker, Director, Laboratory and Food Division, City Board of Health, Jacksonville, read a paper on "Food Inspection." Dr. William deKleine, Medical Director, National Red Cross, read a paper on "Pellagra." Miss Pearl McIver, U. S. Public Health Service, Washington, D. C., read a paper on "Public Health Nursing." Miss Mabel Berry, Director of Social Service for FERA, Florida, read a paper on "FERA Social Service and Public Health Program." Miss Charlotte Conrad, Department of Interior, Indian Service, read a paper on "Nursing among Seminole Indians." Dr. W. V. King, Entomologist, Bureau of Entomology, U. S. Department of Agriculture, read a paper on "Screw Worm Infestation in Florida." Dr. W. E. Dove, Entomologist, Bureau of Entomology, U. S. Department of Agriculture, read a paper on "Progress in Sand Fly Control." Mr. Fred H. Stutz, City Health Department, Coral Gables, read a paper on "Salt Marsh Mosquito Control." Dr. L. L. Williams, Jr., U. S. Public

Health Service, Washington, D. C., read a paper on "FERA and Malaria Control Activities."

At the banquet Tuesday evening, short addresses were given by Dr. Theodore Croft, president of Duval County Medical Society, Dr. C. E. Waller, president of Southern Branch American Public Health Association and Dr. H. Marshall Taylor, president of Southern Medical Association. Dr. T. H. D. Griffitts and Dr. Henry Hanson acted as toastmasters and a number of distinguished guests very appropriately responded to toasts. Mrs. Theodore Croft rendered two vocal solos and received rousing applause.

STATE NEWS ITEMS

President Homer Pearson has returned to Miami from a trip through central and western Florida.

On Saturday, October 13th, he met with the Brevard County Medical Society in Melbourne. Dinner was served at 7:30 and this was immediately followed by a meeting of the Society.

The following morning Dr. Pearson drove to Ocala where he attended a meeting of the Executive Committee.

He visited Lake City and met with the Columbia County Medical Society, October 15th. Luncheon was served at 12:15 at the Blanche Hotel. A round table discussion was held, the subject of which was, as it had been in Melbourne, along political lines.

On Monday evening Dr. Pearson met with the men from Taylor County at Perry. Dinner was served at the Dixie Hotel and was followed by a round table discussion along the same lines as at the other meetings.

On Tuesday afternoon at 3 o'clock at the Women's Club in Quincy, it was Dr. Pearson's privilege and pleasure to meet with the Second District Medical Society. They had a very interesting scientific program, followed by a short talk by President Pearson, which in turn was followed by a cocktail party and by a barbecue at the Country Club.

Immediately following the barbecue, Dr. Pearson drove to Marianna where he met with the Jackson County Medical Society at dinner. In Marianna politics were again discussed.

On Wednesday, October 17, Dr. Pearson met with the Escambia County Medical Society. Following the society meeting the society members were guests at the home of Dr. W. C. Payne where a very delicious buffet supper was served.

On Thursday Dr. Pearson addressed the Florida Dental Society in convention at Pensacola. His discourse will appear in the next issue of the Journal of the Florida Dental Society.

On Friday, the 19th of October, he attended the Florida East Coast Medical Association meeting at Orlando.

* * *

The physicians specializing in the practice of Otolaryngology and Ophthalmology in Jacksonville arranged a series of lectures and demonstrations by Dr. Bernard Samuels, Surgeon, New York Eye and Ear Infirmary and Professor of Ophthalmology, Cornell University, and Mr. E. B. Burchell of the Eno Laboratory, New York Eye and Ear Infirmary. Their subjects were as follows:

Dr. Samuels:

1. Anatomy and Pathology of Eyelids and Conjunctiva.
2. Perforating Wounds and Foreign Bodies in the Globe.
3. Endophthalmitis.
4. Panophthalmitis.
5. Sympathetic Ophthalmia.
6. Tuberculosis of Eyeball.
7. Tumors—intraocular:
 - (a) Sarcoma—metastatic.
 - (b) Glioma.
 - (c) Carcinoma.
8. Glaucoma.
9. Anatomy and Atrophy of Optic Nerve.

Mr. Burchell:

1. Exhibit of anatomy of temporal bone.
2. Bacteriology of conjunctiva.
3. Lantern slide demonstration of the anatomy of the temporal bone and surgical abnormalities.
4. Accessory sinuses and their cariations.
5. Laboratory and its aid to the Otologists.
6. Reminiscences of 40 years in the Eno Laboratory of the New York Eye and Ear Infirmary.

These lectures began at 8:30 p. m., Saturday, November 24, continuing Sunday, November 25, from 9:00 a. m. to 12:00, and from 2:30 to 5:00 p. m. All lectures were demonstrated with numerous pathological and anatomical specimens. The sessions were held in the auditorium on the tenth floor of the Hotel Mayflower.

The Committee on Arrangements were as follows: T. S. Adams, J. L. Boone, W. Jerome Knauer, William S. Manning, J. B. Parramore, Shaler Richardson, Raymond Sanderson, Clar-

ence M. Sandusky, H. Marshall Taylor, Clayton D. Washburn, A. K. Wilson.

* * *

Dr. and Mrs. M. A. Lischkoff spent a few days in Houston, Texas, before going to San Antonio for the meeting of the Southern Medical Association, where Dr. Lischkoff presented a paper before the Otolaryngological Section. They joined the tour of southern doctors to Mexico before returning to Pensacola.

* * *

Dr. C. E. Tumlin of Miami was recently reappointed as a member of the State Board of Medical Examiners by Governor Sholtz.

* * *

Dr. James S. Grable of Tampa recently spent ten days in Philadelphia, attending the meeting of the Interstate Postgraduate Medical Assembly and clinics connected with this meeting.

* * *

Dr. and Mrs. H. A. Barge of Miami announce the birth of a daughter, Margaret Evelyn, at the Jackson Memorial Hospital on November 13.

* * *

Dr. Claude Anderson of Dade City announces his removal to Orlando where he has opened offices in the Exchange Building.

* * *

Members of the Florida Medical Association who appeared on the program of the Florida Tuberculosis and Health Association at a meeting held in Orlando, November 17, were Drs. T. Z. Cason and W. A. Claxton of Jacksonville, W. C. Blake of Tampa, W. C. Page of Cocoa and G. H. Edwards of Orlando.

* * *

Dr. and Mrs. Henry Hanson and Dr. F. A. Brink of Jacksonville motored to San Antonio in November to attend the meeting of the Southern Medical Association. Dr. Hanson presided over the meeting of the National Malaria Committee which was held in conjunction with the Southern Medical Association meeting. He read two papers, as follows: "The Need for Continued Research in Malaria" and "An Enlarged Nursing Program and Maternal Mortality."

* * *

Dr. James R. Boulware, Jr., of Lakeland attended the Regional Meeting of the Academy of Pediatrics held in New York, October 19 and 20. The day following the meeting Dr. Boulware successfully passed the examination given by the American Board of Pediatrics.

Dr. Lloyd J. Netto of West Palm Beach spent some time at the Vanderbilt Hospital, Nashville, and at the Mayo Clinic, Rochester, during the month of September.

* * *

Dr. H. Marshall Taylor of Jacksonville was signally honored at the recent meeting of the Southern Medical Association by being elected to the presidency of that organization. Dr. Taylor is a past president of the Florida Medical Association and of the Duval County Medical Society. He has been chairman of the Eye, Ear, Nose and Throat Section of the Southern Medical Association and an active member of the American Otological Society, the American Laryngological Society, the American Triological Society and the American College of Surgeons.

* * *

Dr. Luther W. Holloway of Jacksonville was honored by the Southern Medical Association at its annual meeting in November by being elected chairman of the Section on Pediatrics.

* * *

The second annual scientific meeting of the Georgia Pediatric Society was held in Atlanta, December 13.

* * *

Many members of the Association attended the first meeting of the Southeastern Branch of the American Urological Association which was held in Atlanta, December 7 and 8. Prominent urologists from New York, Rochester, Minn., St. Louis, Chicago, Memphis, Cleveland and Minneapolis were featured speakers at this meeting. Eleven thousand invitations were sent out by the Association to physicians in Louisiana, Alabama, Florida, Georgia, South Carolina, North Carolina and Tennessee.

* * *

The American Association for the Study of Goiter again offers the Van Meter Prize Award of $300 and two honorable mentions for the best essays on the subject of goiter provided they meet the standards of the award committee. The essays should be based on original research work on the subject of goiter, preferably its basic cause. The prize essay or its abridgement is to be presented at the annual meeting of the Association to be held in Salt Lake City, Utah, in June, 1935.

Competing manuscripts should be in the hands of the Corresponding Secretary, W. Blair Mosser, M. D., Kane, Pa., not later than April 1, 1935.

The first prize of $300 for the 1934 meeting was awarded to M. A. B. Brazier, Ph.D., B.Sc., London, England, for her essay "The Impedance Angle Test for Thyrotoxicosis."

First honorable mention was awarded Prof. Ugo Cerletti, Genoz, Italy, for his essay, "Three Years of Experimental Research in the Etiology of Endemic Goitre."

Second honorable mention was awarded D. Roy McCullagh, M.D., Cleveland Clinic, Cleveland, Ohio, for his essay "Studies in Blood Iodine Using a New Chemical Method."

JAMES MARTIN JOSHUA LUKE

On October 8, 1934, the medical profession lost one of its most valuable men. Nothing more fitting and descriptive of Dr. Luke's life can be written than that by Dr. Roy Holmes, president of Dade County Medical Society:

"Calm and considerate. Gentle and tolerant. The acme of kindness both in his dealings with his colleagues and in his relationship with his patients. As umpretentious as a wild rose, as scrupulously clean, morally and spiritually, as the evening sunset which drew the last dark curtain between his world and ours. A gentleman without effort, a friend without blemish, a physician without enemies, a husband without fault. These qualities made his life an exceptional one. These wonderful attributes which only he seemed to possess so bountifully have been an inspiration to us all. We shall miss him. We shall carry on without him. But there are those among us who shall always feel the inspiration which began with his fellowship and there are many others, yes, many of us who, through contact with him, have been given a higher and nobler definition of the true physician."

Dr. Luke was born in Fitzgerald, Georgia, December 28, 1888. He graduated from Louisville Medical College, Louisville, Kentucky, in 1913. He served during the World War as Captain in the Aviation Corps, where he did valiant service for his country. Dr. Luke was past president of the Victoria Hospital Staff, a Mason, and a Legionnaire. He is survived by his widow, Mrs. Eva Bernice Luke.

WANTED—To purchase good used or new microscope. Write description, make and price to Box 81, Jacksonville, Florida.

Application blanks are now available for space in the Scientific Exhibit at the Atlantic City Session of the American Medical Association, June 10-14, 1935.

Persons desiring application blanks should address a request to the Director, Scientific Exhibit, American Medical Association, 535 North Dearborn Street, Chicago, Illinois, before February 25, 1935.

* * *

Dr. Albert S. Munson, 84, a resident of DeLand for the past 54 years, died October 22 at his home. He had been in failing health for some time. Honorary membership in the Florida Medical Association was conferred upon Dr. Munson at the 1934 meeting of the Association.

* * *

Dr. Shaler Richardson of Jacksonville spent two weeks during the month of October in New York City.

* * *

A very successful meeting was held by the Florida Midland Medical Society at Bartow, October 25. The following program was presented:

"Surgical Accidents Occurring in Urinary Tract Following Operation," James L. Estes, Tampa.

"Certain Aspects of the Problem of Cardiac Pain," E. W. Bitzer, Tampa.

"Torsion of Mesentery," Duncan McEwan, Orlando.

"Some Problems in the Management and Care of Infants and Children," W. E. Sinclair, Orlando.

"Anal Puritis—Significant of Cryptitis, Papillitis, and Other Rectal Pathology," Jack Halton, Tampa.

"Laryngo-Fissure for Cancer of the Larynx," William Patterson, Tampa.

The following officers were elected for the ensuing year:

President—Robert C. Black, Plant City.
First Vice-Pres.—W. E. Sinclair, Orlando.
Second Vice-Pres.—R. L. Hughes, Bartow.
Secretary-Treasurer—H. O. Brown, Tampa.

COMPONENT COUNTY SOCIETIES

DADE COUNTY MEDICAL SOCIETY

At the December meeting of the Dade County Medical Society, the following officers were elected for 1935:

President—W. W. McKibben.
Vice-President—M. Jay Flipse.
Secretary—Robert T. Spicer.

Treasurer—H. A. Barge.
Censors—Duncan Owens, R. N. Burch, and E. B. Maxwell.

Every effort is being put forth by the Dade County Medical Society to place Miami in readiness for entertaining the American Medical Association in 1936, should the A. M. A. accept Florida's invitation to meet in that city. The following resolution was recently passed by the Society:

"WHEREAS, The City of Miami is rapidly becoming one of the leading convention cities of the United States, and

"WHEREAS, There are many large associations that need a large auditorium or convention hall in which to hold their convention meetings, and

"WHEREAS, The American Medical Association is such an association, and

"WHEREAS, The State Medical Association, the Dade County Medical Society, and the City of Miami have extended an invitation to the American Medical Association to meet in Miami in 1936, and

"WHEREAS, The American Medical Association will not accept that invitation unless suitable convention halls are provided;

"Be it therefore resolved: That the Dade County Medical Society petition the Board of Commissioners of the City of Miami to put forth every effort to build suitable convention halls for the American Medical Association and for other large associations that will need such halls, in convention.

DE SOTO-HARDEE-HIGHLANDS COUNTY MEDICAL SOCIETY

The DeSoto-Hardee-Highlands County Medical Society met at Simmons Hotel, Tuesday, October 9th, at 8 p. m. with the following members present: Drs. Highsmith, Chandler, Alexander, Peacock, Poucher, McSwain, Bevis, Spears, Kayton, Weems, McKnight and Martin.

The visitors were Dr. H. K. Murphy, Bartow; Dr. G. H. Carefoot, Ft. Meade; and Drs. Leland Carlton and A. R. Knauf, Tampa.

After reading the minutes, a report was heard from two men in charge of relief in Hardee County, asking that the doctors of Hardee County organize and divide FERA work. This was referred to doctors of Hardee County for action.

Dr. Knauf of Tampa then read a paper on "The Enlargement of the Prostate Causing Obstruction at Neck of Bladder, and Treatment."

This was discussed by Weems, Peacock, Carlton, Murphy, and Highsmith.

DUVAL COUNTY MEDICAL SOCIETY

The annual election of officers of the Duval County Medical Society was held December 5, with the following result:
President—E. T. Sellers.
Vice-President—B. F. Woolsey.
Secretary—Charles B. Mabry.
Treasurer—J. W. Hayes.

LAKE COUNTY MEDICAL SOCIETY

Dr. Lon Grove of Atlanta was guest of honor at the meeting of the Lake County Medical Society held in Tavares, November 7. Dr. Grove presented a paper on "Surgical Aspects of Gall-Bladder and Results of 84 Operations Thereon." Thirty physicians were in attendance, including members of the Orange and Volusia societies.

PASCO-HERNANDO-CITRUS COUNTY MEDICAL SOCIETY

Dr. John J. Bourke entertained the Pasco-Hernando-Citrus County Medical Society, at Dade City, Thursday evening, November 8th.

Dinner was served at the Edwinola Hotel, followed by a scientific meeting in the hotel, Dr. Harvard, Vice-President, presiding.

Dr. S. H. Etheredge of Tampa read a paper on "General Edema and Chronic Nephritis," which was discussed by those present. Several interesting case reports were given and discussed.

Dr. S. C. Harvard invited the Society to meet with him in Brooksville on December 13.

Those present: Drs. J. T. Bradshaw, J. J. Bourke, G. R. Creekmore, W. Wardlaw Jones, S. C. Harvard, and visitors, Drs. S. H. Etheredge, and Virgil Bradshaw, both of Tampa.

PINELLAS COUNTY MEDICAL SOCIETY

At its annual meeting held in St. Petersburg, October 5th, the Pinellas County Medical Society elected the following officers:
President—Dr. W. W. Harden, St. Petersburg.
First Vice-Pres.—Dr. W. D. Anderson, Largo.
Second Vice-Pres.—Dr. J. A. Hardenbergh, St. Petersburg.
Secretary—Dr. O. O. Feaster, St. Petersburg.
Treasurer—Dr. W. C. McConnell, St. Petersburg.
Censors for three years—Dr. E. A. Heibner, St. Petersburg; Dr. L. Lambdin, St. Petersburg.

The Society unanimously indorsed the Resolution adopted by the Hillsboro County Medical Society September 4, ". . . That each and every applicant for admission to practice the healing art in this State be required to present absolute evidence of full citizenship in the U. S. A. . . ."

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OFFICERS INSTALLED AT SOUTHERN MEDICAL AUXILIARY LUNCHEON

At the conclusion of the luncheon given Wednesday, November 14, on the St. Anthony Hotel roof garden for the wives of doctors attending the Southern Medical Association convention, the newly elected officers of the Woman's Auxiliary to the Southern Medical Association were installed by Mrs. Preston Hunt of Corsicana, president of the State Auxiliary.

Mrs. J. Bonar White of Atlanta, Georgia, who was unable to attend the meeting, is the new president. In her behalf, the gavel was accepted from the retiring president, Mrs. Southgate Leigh, by the first vice-president, Mrs. Frank Haggard of San Antonio. Other officers include President-elect, Mrs. Oliver Hill, Knoxville, Tenn.; second vice-president, Mrs. W. K. West of Oklahoma City, Okla.; recording secretary, Mrs. Francis E. LeJeunge of New Orleans, La.; corresponding secretary, Mrs. E. A. Allen, Atlanta, Ga.; treasurer, Mrs. A. G. Wilde, Jackson, Miss.; historian, Mrs. Southgate Leigh, Norfolk, Va.; parliamentarian, Mrs. Edward Jelks, Jacksonville, Fla.

Members of the nominating committee were: Mrs. S. A. Collom of Texarkana, Texas; Mrs. L. L. Polk, Purvis, Miss.; Mrs. A. A. Herold, Shreveport, La.; Mrs. J. J. Gavle, Norman, Okla.; and Mrs. S. H. Watson, Waxahachie.

At the luncheon, Mrs. H. O. Wyneken, general chairman, extended a welcome to the visitors and introduced Mrs. Frank Haggard, president of the State Auxiliary, who presented the guest speakers, Dr. S. E. Thompson of Kerrville, president of the Texas Medical Society; Dr. Seale Harris of Birmingham, Ala., a member of the advisory council of the Southern Medical Association; Dr. Leslie Moore of Dallas, president of the Woman's Auxiliary to the Southern Medical Association. Other honored guests introduced were Mrs. Robert W. Tomlinson, president of the American Medical Association Auxiliary; Mrs. Roger N. Herbert, president-elect, of the A. M. A. A.; Mrs. Preston Hunt; Mrs. A. C. Scott, honorary life president of the Texas Auxiliary; Mrs. R. C. Red of Houston, past national auxiliary president; Mrs. S. C. Thompson of Kerrville, Mrs. John O. M. Reynolds, Mrs. Seale Harris, Mrs. E. H. Carey and Mrs. C. K. Quin.

Resolutions of appreciation were read thanking the Texas and Bexar County Auxiliaries for the arrangements made for the pleasure of the Southern Medical Association; the press, and members of the St. Anthony Hotel staff.

For the entertainment of the assembled guests, Mexican dances were presented by Marta Gallardo and Fernando Ramos, who were in native costumes. Jose Caballero, also in costume, was a picturesque figure as he strolled about the roof strumming his guitar and singing Mexican songs. Members of the orchestra were in costume and played a group of Mexican selections.

The roof garden formed a tropical setting with its palm trees, banana trees and cages with various types of tropical birds. The Mexican motif was further emphasized in the table decorations.

Mrs. Wyneken expressed her appreciation to Mrs. William E. Nexbit, chairman of the luncheon, and to Joske Bros. Company, Garcia Flower Shop, The Mexican Arts and Crafts Shop, the Casa Flower Shop, the Pet Shop for the decorations loaned by them. Covers were laid for more than 500 persons.

Immediately following luncheon the visitors were taken for a drive to historical points about the city, stopping for tea at the Spanish Governor's Palace. The tea table in the banquet hall was colorfully decorated with Texas vegetables artistically arranged in a large Mexican tray.

It was announced by Mrs. Edward Coyle, chairman of registrations, that 628 visitors had registered.

It is indeed gratifying to learn that Dr. H. Marshall Taylor, eye, ear, nose and throat specialist, of Jacksonville, was chosen president of the Southern Medical Association and Dr. Luther W. Holloway, specialist of children's diseases, was made

Chairman of the Section on Pediatrics. Mrs. Edward Jelks, wife of Dr. Edward Jelks of Jacksonville, was elected Parliamentarian of the Southern Medical Auxiliary.

We feel that such high honors conferred upon members of our own Florida Medical organization reflects credit to our state.

* * *

Duval Medical Auxiliary and Doctors Guests of Dr. Alan Brown

The Woman's Auxiliary to the Duval County Medical Association entertained its members and their husbands with an oyster roast Saturday evening, at the picturesque home of E. C. Brown and his son, Dr. Alan Brown, in Arlington, on the St. Johns River.

Mrs. Theodore G. Croft, Social Chairman, planned the delicious supper which was served in the open. The guests enjoyed strolling through Mr. Brown's beautiful grounds with moss-covered oaks, fountains, streams and pools inhabited by interesting little ducks; a variety of pretty shrubs and plants; and a unique log cabin furnished with Colonial pieces and rare antiques, added much delight to the occasion.

Those enjoying this party were: Dr. and Mrs. Theodore G. Croft, Dr. and Mrs. Gordon Ira, Mrs. Frederick J. Waas, Dr. and Mrs. O. P. Broadbent, Dr. and Mrs. A. K. Wilson, Dr. and Mrs. John H. Mitchell, Dr. John B. Black, Mrs. Elizabeth Klingenberg, Dr. O. E. Harrell, Dr. and Mrs. J. W. Hayes, Dr. and Mrs. S. M. Copeland, Dr. and Mrs. B. A. Chapman, Dr. and Mrs. C. W. Johnston, Dr. and Mrs. Banks H. Goodale, Dr. Allan Brown and Mr. E. C. Brown.

* * *

Dade County Auxiliary

The Woman's Auxiliary to the Dade County Medical Society met November 12th, at the home of Mrs. Rothwell Lefholz in Coral Gables. A delicious covered dish luncheon was served at noon.

In the absence of the president Mrs. H. A. Leavitt presided over the business meeting. Mrs. Edward B. Quinan of the Dade County Tuberculosis Association was the guest speaker. The Auxiliary voted to sponsor the sale of the tuberculosis Christmas seals again this year. Mrs. E. J. Hall and her committee will be in charge of the seals. A scholarship fund was started to aid the physicians' widows and children. Five new members were welcomed into the Auxiliary: Mrs. Eugene Maxwell, Mrs. A. D. Amerise, Mrs. F. B. Welch, Mrs. J. D. Stuart and Mrs. Milton Coplan. Officers elected were:

President, Mrs. H. A. Leavill; First Vice-President, Mrs. E. J. Hall; Second Vice-President, Mrs. W. M. Goodson; Recording Secretary, Mrs. Gerard Raap; Corresponding Secretary, Mrs. Roy J. Holmes; Treasurer, Mrs. William Barge.

STANDING COMMITTEES

Hygiene, Mrs. M. J. Flipse; Membership, Mrs. W. P. Lanier; Hospitality, Mrs. Rothwell Lefholz; Social, Mrs. Allan Jones; Public Relations or Health, Mrs. George MacDonald; Program, Mrs. E. J. Hall; Publicity, Mrs. William J. Barge.

Attending the meeting were: Mrs. H. A. Leavitt, Mrs. Allan Jones, Mrs. Rothwell Lefholz, Mrs. Milton Coplan, Mrs. J. D. Stuart, Mrs. P. B. Welch, Mrs. A. D. Amerise, Mrs. Eugene Maxwell, Mrs. George MacDonald, Mrs. Arthur Weiland, Mrs. E. J. Hall, Mrs. W. M. Goodson, Mrs. Arthur Walters, Mrs. W. Duncan Owens, Mrs. S. Aronovitz, Mrs. S. E. Chambers, Mrs. John R. Richardson and Mrs. William J. Barge.

ADVERTISERS' NOTES

Lilly Research Laboratories Formally Opened

More than a thousand investigators and research workers were present at the formal opening of the new Lilly Research Laboratories at Indianapolis on October 11. The gathering of distinguished visitors representing many noted bodies and famous institutions in this and foreign countries as well, assembled in a mammoth tent erected for the occasion adjacent to the Lilly Laboratories.

At the formal opening exercises, in the afternoon, Eli Lilly, head of the Lilly organization, presided as chairman. Mr. J. K. Lilly, chairman of the board of directors, was introduced and responded briefly on "Research in Manufacturing Pharmacy" from the time of his entrance in the organization in 1876 up to the present, when there is so much evidence of the fact that medical science, in becoming an integral part of our social structure, has, in turn, become in a broad measure dependent upon industrial development.

Following Mr. Lilly's remarks, Dr. Irving Langmuir, director of research for the General Electric Company, discussed "The Unpredictable Results of Research." The speaker stressed the point that fundamental research should be pursued by industrial corporations regardless of any immediate possible commercial return therefrom. He gave an account of his purely theoretical gas absorption studies which ultimately led to the development by the General Electric Company of their present highly efficient electric light bulb.

The chairman then introduced Sir Frederick Banting, who talked on "The Early History of Insulin." He gave an account of the early experiments conducted by Dr. Best and himself which first demonstrated the existence of Insulin, and expressed his great appreciation of the cooperation which he and his associates had received from the staff of the Lilly Research Laboratories in the development of a practical, large-scale procedure for the production of Insulin.

Sir Henry Dale, director of the National Institute for Medical Research, London, and secretary of the Royal Society, was the last speaker on the afternoon program. He chose as his topic "Chemical Ideas in Medicine and Biology." Sir Henry spoke of the immediate objectives of research in such laboratories as those of Eli Lilly and Company, and of their natural and proper differences from those of the laboratories supported by academic or public endowment. It was his thought, however, that the differences in result for the progress of medical science are often more formal than real. He expressed the hope that the growth of cooperation between those working in these different spheres might yet bring to many the rather rare privilege that had come to him of migrating from one to the other and back again, and thus of knowing at first hand the best that each can offer.

The afternoon speaking program was followed by an inspection of the new laboratories, the party being divided into small groups in the charge of guides.

In the evening a banquet was tendered the out-of-town guests. Mr. J. K. Lilly served as toastmaster and responses were made by Sir Henry Dale; Dr. Elliott P. Joslin, of Boston; Dr. George R. Minot, of Boston; Dr. Frank R. Lillie, of Chicago; Dr. George H. Whipple, of Rochester, N. Y.; Dr. Carl Voegtlin, of Washington, D. C., and Dr. G. H. A. Clowes, head of the Lilly Research Laboratories.



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National pneumonia serums should be administered as soon as a diagnosis of lobar pneumonia is made. The sputum should be examined for the type of pneumococcus infecting the patient.

The initial dose of concentrated serum should be 10 cc. in milder infections and 20 cc. for patients in a highly toxic condition or when serum treatment is instituted later than the third day of the disease. The doses of serum should be increased to 20 cc. and repeated at intervals of 6 to 8 hours until there is a marked drop in the temperature and the toxic symptoms are relieved. It is advisable to continue serum treatment, at longer intervals, until the temperature drops to the normal level.

Dr. Ronald L. Hamilton (The Bulletin of the Guthrie Clinic, Robert Packer Hospital, Sayre, Pa., July, 1934, and Medical Record, September 19, 1934, page 298) reported on the effects of treatment of 178 pneumonia patients, 32 of which were treated with National concentrated pneumonia serums and 146 were treated without serum. The amount of serum injected into individual patients ranged from 20 to 60 cc.

The mortality in patients, treated with serum, was 9.4 per cent, in patients treated without serum the mortality was 34.8 per cent, a reduction in mortality of patients with serum of approximately 70 per cent.

In the 32 serum treated patients complications developed in 10 patients or 31.2 per cent, in the 146 patients treated without serum complications developed in 74 patients or 50.7 per cent, a reduction in complications, in serum treated patients of approximately 40 per cent.

Dr. Hamilton states: "It was noticeable in many of these cases where the serum was administered within the first 36 hours, that they aborted their pneumonias by the end of the third day. So striking have been the benefits obtained by the use of this serum (National Drug serum) that we



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One of the concentrated recipes from "Reinforced Diet Recipes"

BAKED CUSTARD

6 teospoons KLIM	½ teaspoon vonillo
2 toblespoons sugar	1 cup boiling water
1 egg	Few groins solt

Few groins nutmeg

Mix KLIM, sugar and salt. Add slightly beaten egg and vanilla. Beat smooth. Gradually add boiling water. Paur in a baking pan ar custard cup. Sprinkle with nutmeg, place in a pan af hat water and bake in a slow aven (300° F.) abaut 40 minutes or until custard sets. A knife blade inserted will came out clean when custard is dane. Valume: 1¼ cups.

This recipe furnishes ½ cup af mi!k (84 calories) aver narmal recipe.



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Borden Abstracts Summarized

Pasteurization of milk does not appreciably alter its nutritive qualities, in the opinion of Professor E. V. McCollum, whose paper on this important subject is reviewed in Abstract No. 2055. Pasteurization is, however, effective in reducing the incidence of certain diseases which may be spread by contaminated raw milk.

Successful use of Klim powdered whole milk in concentrated diets for the treatment of childhood tuberculosis is reported in Abstract No. 2057. A method for increasing the vitamin B content of dried milk is outlined in Abstract No. 2062.

Lactose is not only a valuable carbohydrate for infant feeding formulas, but its use results in a favorable change in the intestinal flora, according to the paper which is the basis of Abstract No. 2060.

Advantages of vitamin D milk for infants and children, for expectant and nursing mothers, and in the formation of sound teeth are set forth in Abstract No. 2058. The value of irradiated evaporated milk in the dental diet is described in Abstract No. 2061.

Failure of viosterol to protect premature infants against rickets is reported in Abstract No. 2059.

Amplified milk diets in the treatment of fever patients are advocated and described in the article mentioned in Abstract No. 2063.

A plea for increased consumption of milk in this country is contained in the editorial reviewed in Abstract No. 2056.



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[1]Jour. A. M. A., 101, July 15, 1933, 187. [2]Jour. A. M. A., 101, 1933, 1449.

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SCHEDULE OF MEETINGS—COMPONENT SOCIETIES FLORIDA MEDICAL ASSOCIATION

COUNTY SOCIETY	SECRETARY	MEETINGS				Dues Paid.
		Date	Time	Place	Luncheon?	
Alachua	Harry M. Merchant, M.D., Gainesville.	2nd Tuesday	12:00 Noon	White House Gainesville	Yes.	90%
Bay	Allen H. Miller, M.D., Millville.					71%
Brevard	L. K. Hicks, M.D., Melbourne.	2nd Tuesday		Varies	Yes.	67%
Broward	O. C. Brown, M.D., Ft. Lauderdale.	Last Wednesday.	8:00 P.M.	Elks' Hall Ft. Lauderdale	No.	94%
Columbia	T. H. Bates, M.D., Lake City.	1st Monday	7:30 P.M.	Blanche Hotel Lake City		100%
Dade	Robert T. Spicer, M.D., Miami.	1st Friday	8:30 P.M.	Club Room Huntington Bldg. Miami	Occasionally.	99%
DeSoto-Hardee-Highlands	L. W. Martin, M.D., Sebring.	2nd Tuesday	8:00 P.M.	Varies	Yes.	93%
Duval	B. F. Woolsey, M.D., Jacksonville.	1st Tuesday	8:15 P.M.	Mayflower Hotel Jacksonville	No.	83%
Escambia	J. M. Hoffman, M.D., Pensacola.	2nd Tuesday	8:00 P.M.	Board of Health Building Pensacola	No.	76%
Hillsboro	John S. Helms, Jr., M.D., Tampa.	1st Tuesday	8:00 P.M.	Tampa Municipal Hospital Tampa	No.	100%
Jackson	Lewis Pierce, M.D., Marianna.	2nd Tuesday	7:30 P.M.	Hotel Chipola, Marianna	Yes.	91%
Lake	W. L. Ashton, M.D., Umatilla.	1st Thursday	12:30 P.M.	Eustis	Yes.	94%
Lee	Rohley D. Newton, M.D., Ft. Myers.	3rd Friday	7:30 P.M.	Lee Memorial Hospital Ft. Myers	No.	100%
Leon-Gadsden-Liberty-Wakulla-Jefferson	O. G. Kendrick, M.D., Tallahassee.	Quarterly	8:00 P.M.	Varies	Yes.	100%
Madison	Geo. O. Davis, M.D., Madison.					100%
Manatee	W. D. Sugg, M.D., Bradenton.	3rd Tuesday	7:00 P.M.	Whitfield Country Club Bradenton	Yes.	100%
Marion	Richard C. Cumming, M.D., Ocala.	3rd Thursday	12:30 P.M.	Marion Hotel Ocala	Yes.	100%
Monroe	W. R. Warren, M.D., Key West.	1st Sunday	9:00 P.M.	Varies	Yes.	100%
Orange	John A. Pines, M.D., Orlando.	3rd Wednesday	8:30 P.M.	Varies	No.	100%
Palm Beach	R. Henry Baldwin, M.D., W. Palm Beach.	4th Monday	8:00 P.M.	Good Samaritan Hospital W. Palm Beach	No.	100%
Pasco-Hernando-Citrus	Geo. R. Creakmore, M.D., Brooksville.	2nd Thursday	7:00 P.M.	Varies	Yes.	100%
Pinellas	O. O. Feaster, M.D., St. Petersburg	1st Friday	8:00 P.M.	Assembly Room, 5th floor, P. & L. Bldg. St. Petersburg	No.	100%
Polk	J. R. Boulware, Jr., M.D., Lakeland.	2nd Wednesday in Feb., Apr., June, Aug., Oct., Dec.	1:00 P.M.	Lakeland	Yes.	98%
Putnam	E. W. Warren, M.D., Palatka.	2nd Thursday	7:00 P.M.	James Hotel, Palatka	Yes.	100%
St. Johns	Reddin Britt, M.D., St. Augustine.	3rd Tuesday	8:30 P.M.	Varies	Yes.	100%
St. Lucie-Okeechobee-Indian River-Martin	J. D. Parker, M.D., Stuart.	3rd Thursday	8:00 P.M.	Varies	Yes.	100%
Sarasota	J. E. Harris, M.D., Sarasota.	2nd Tuesday	8:30 P.M.	Varies	Occasionally.	100%
Seminole	J. T. Denton, M.D., Sanford.	2nd Monday	7:00 P.M.	City Hospital Sanford	Yes.	100%
Sumter	W. E. Mitchell, M.D., Coleman.	2nd Tuesday		Varies	No.	100%
Taylor	C. A. O'Quinn, M.D., Perry.	Last Friday	8:00 P.M.	Dixie-Taylor Hotel Perry	Yes.	100%
Volusia	Joseph H. Rutter, M.D., Daytona Beach.	2nd Tuesday	7:30 P.M.	Varies	Yes.	94%
Walton-Okaloosa	A. G. Williams, M.D., Lakewood.	3rd Thursday	8:00 P.M.	Varies	Occasionally.	100%

NOTE—Secretaries: Please submit information to complete the above schedule.

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NEXT SESSIONS Florida Medical Association, Ocala, May 13, 14, 15, 1935.
American Medical Association, Atlantic City, June 10-14, 1935.

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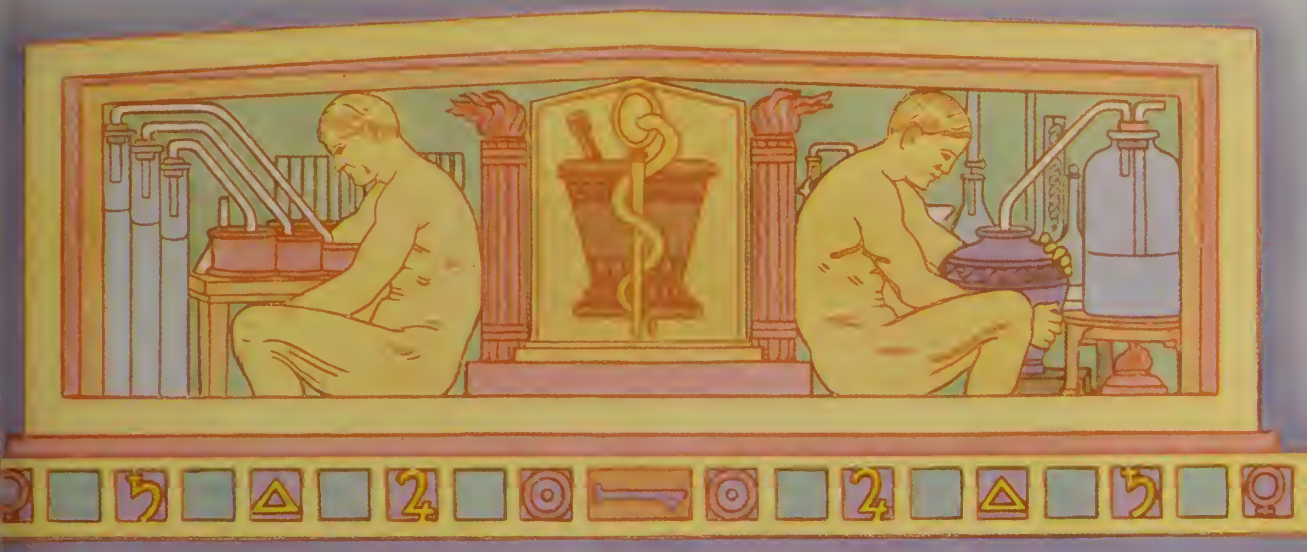
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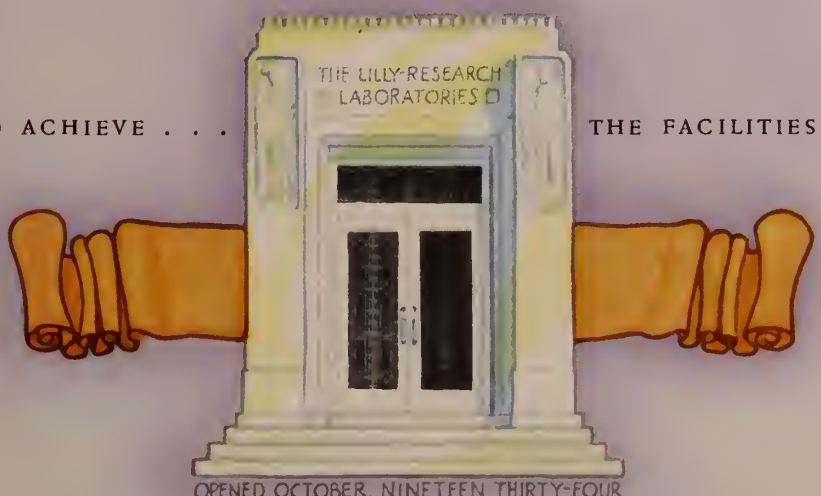
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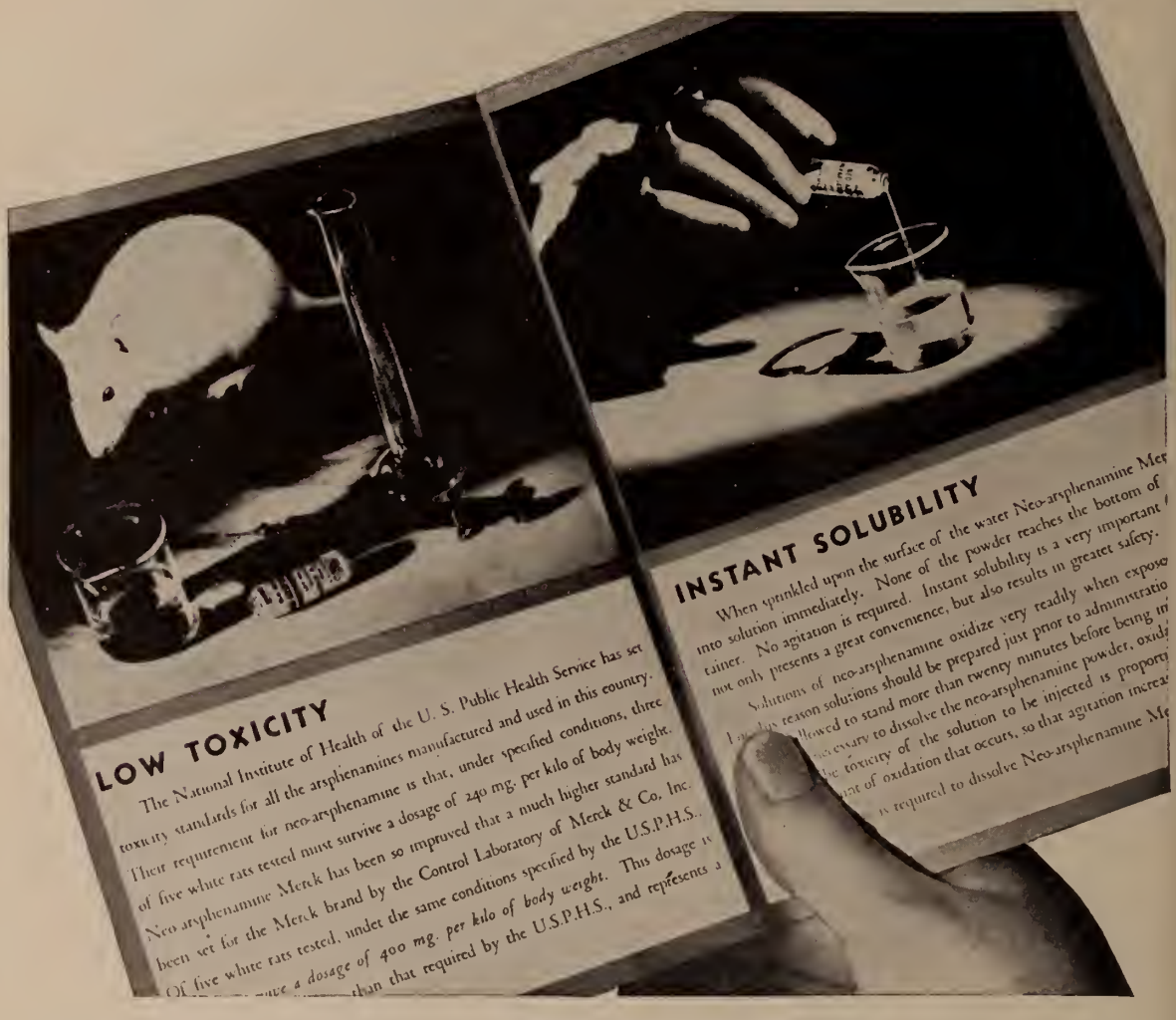
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RECENT PROGRESS IN AVIATION MEDICINE*

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The field of aviation medicine is in its entirety a quite recent development. Airplanes and lighter-than-air aircraft were, up until about 1910, of but curiosity-arousing interest, as they were chiefly exhibited and flown from the economic standpoint of thrilling the crowd.

About this year—1910—the ranking nations of the world began experimenting with various types of aircraft for the purpose of a supplementary aid to their armaments. All aircraft continued in this category as a supplementary aid to armies and navies until the late World War when the day arrived that a young and most adventurous pilot on an observation and photographic flight took his pistol into the air with him and shot down an enemy airplane out on a like mission of observation. The enemy retaliated by sending its next flight into the air with rifles. Then, of course, it was but a few weeks until nearly all planes were equipped with machine guns. When this occurred a new offensive arm became a reality. This reality was soon spoken of and referred to as "Control of the Air." Its many various problems and phases are not the concern of this article, other than from the viewpoint of a flight surgeon, or a doctor interested in a professional way with aviation. To a navy flight surgeon it is a subject of discussion and exchange of ideas that is always of interest and bears directly upon his professional views and duties. To him control of the air means fitness of pilots, observers and other flying personnel coming under his care and observation. This entails selection of pilots by prescribed careful and complete physical examinations and psychological studies, and the maintenance and supervision of their physical good health and mental well-being. In a lesser degree this applies also to the other members of an aeronautical unit, but it is nevertheless of great import, as it may be that any deficiency in one of these factors might be of sufficient degree to seriously affect the morale of a unit, and this in turn directly reflects upon the actual flyer or pilot in his highly specialized work as a military combatant in the air.

It therefore becomes of paramount importance to aviation or "control of the air" that, from the viewpoint of a physician working with and for military and naval aviation, the greatest possible care and skill be used in the selection of individuals prior to their assignment to flying instruction and duty.

Beginning in September, 1928, and still under investigation, a study of 1,305 continuous cases or individuals regularly assigned to naval flight instruction with a hope of completing the prescribed course and going out into the Navy as naval aviators, and subsequently many of them into private and commercial flying, was instituted at the Naval Air Station, Pensacola, Florida. Of these 1,305 flight students only 640 or 49% qualified, as against 665 or 51% who failed. Each of these young men was given a standard psychological examination by a flight surgeon before training was commenced and assigned into one of two categories—namely (1) good aviation material and (2) poor aviation material.

The above percentage and figures are based on what actually happened, but had the students, who were classified as poor aviation material been eliminated at that time and a like number been trained who would have been in the category of good aviation material, the estimated results would be 941 or 72% qualified as against 364 or 28% failed.

To be more explicit, if the latter method had been pursued there would have been 941 estimated student flyers graduated as naval aviators and pilots as compared to 640 who did actually complete the course, an increase of 301 individ-

*Read before the Sixty-first Annual Meeting of the Florida Medical Association, Jacksonville, April 30, May 1 and 2, 1934.

uals, or roughly 50% better results in training than actually existed. From the other angle, the attrition would have been only 364 failures as against the 665 who did actually fail, and here again the improvement would have been approximately 50%.

From these 1,305 student flyers there actually were 479 individuals selected as good aviation material. Of this number 372 or 77.6% completed the course as naval aviators and only 107 or 22.4% failed. The remaining 826 individuals of this group of 1,305 were placed in the other category, as poor aviation material, and of this number only 268 or 32.5% completed the course, and the large number of 558 or 67.5% failed to complete the course as naval aviators.

It is a well-known and universally recognized fact throughout the naval service that all naval aviators do not possess the same and like degree of flying skill. And for the purpose of making a check and comparison of this skill or "ability to fly," in flying on the greater part of these 640 individuals, who actually completed the course of flying instruction at Pensacola, all data in any way referable to a crash on their part in which they were actually the pilot of the plane or planes, were carefully gathered and correlated over a period of nearly four years.

The figures are clear-cut and conclusive. The individuals classed as good aviation material had a crash rate of 0.2% while the other group had a crash rate of 0.65%, or over three times as many crashes. These crashes were not in all cases fatal, but some of these were the cause of death to other occupants of the plane or planes concerned.

On checking over the time of students graded as poor aviation material, it was found that 278 of these individuals during training spent 98 years, 2 months and 1 day as student flyers. They were then dropped from instruction and did not complete the course. The cost of training at a naval air station is expensive and therefore it is quite evident that the economic side of the proposition should also be a determining factor relative to the selection of student flyers, as the estimated cost of training and qualifying a naval aviator is $8,800.00 or about $27.00 an hour.

The classification of student flyers into good or poor aviation material was primarily based on a prediction made as to the student's ultimate success or failure to qualify as a naval aviator. This prediction or classification was determined by the examining flight surgeon through association and study of each student. The character components found to be most necessary and favorable to the student's chance of success were individual stability, aggressiveness and courage, while any instability or neurotic tendency on the student's part made the prediction of failure correct to the degree shown in the before-mentioned percentages.

A now frequent phenomenon encountered during combat flying was first brought to the attention of flight surgeons and airplane designers by the statement of one of this country's recognized racing pilots during an international air meet some years ago. He stated that after making his dive to gain speed before going into the measured and clocked straight-a-way course that upon pulling the nose of his plane up for level flight that "everything went black." This pilot was at first ridiculed in the military services and his statement referred to as a publicity seeking stunt. However, as airplane diving and pull-out speeds increased this phenomenon was soon a recognized fact. There was serious apprehension at that time that the maximum air speed would soon be reached because of the physical limitations of the pilots. Interested flight surgeons from data collected and from personal experience soon established that this "blackness" was caused by a mechanical cerebral anemia, or syncope. This is due to the greatly increased gravity of high diving speeds and then sudden reversal of direction upwards. The reversal of direction upward forces the flyer's blood to his splanchnic blood vessels as the greatly accentuated gravitation effect overcomes the blood pressure. This syncope is of but momentary duration, and seems to leave no demonstrable symptoms or sequellae, and apparently will not limit the increased straight or forward airplane speeds of the future, by reason of the human physiological limitations.

Pilots soon learned that by yelling lustily at the moment of pulling up that this blackness was markedly reduced in occurrence and degree. The explanation is that in yelling the abdominal muscles and diaphragm are fixed, which increases the intra-abdominal pressure to such a degree that the blood cannot so readily gain access to the splanchnic vessels. It is now a common practice by pilots to either yell or grunt loudly to fix the abdominal muscles and diaphragm when

this phenomenon of going black is about to occur in an airplane maneuver.

During the last year and a half considerable research work has been done regarding this syncope, as to its continued experience; at what diving speeds and reversal of direction; the length of time of this reversal most severe reactions are encountered; what their after effects might be; and what measures and devices can be used to prevent its occurrence. Considerable data have been gathered, and certain facts have been established but are not available for discussion as they are considered of military value primarily and do not apply seriously in commercial and personal flying.

Soon after the Navy began using large numbers of air-cooled motors with short exhaust stacks or manifolds in aircraft it was a common experience of flight surgeons to be approached by pilots complaining of headache. This headache varied from a feeling of tightness across the forehead to severe headaches which were occasionally accompanied with weakness, dizziness, nausea and vomiting.

At about this time ethyl fluid was also introduced as an adjunct to the gasoline, and its dangers were well advertised along with the instructions for its use. The consensus of opinion among the aviators as the cause of their headaches was that they were being subjected to the combustion fumes of the motor, and that these fumes were highly potent because of the lead therein contained from the ethyl fluid; or in other words they were being subjected to an acute lead poisoning from the tetra-ethylene mixed with the gasoline. This opinion as to the cause of their headaches became generally accepted and carbon monoxide poisoning was not considered in a serious investigative manner until the tragic death of one of the outstanding naval aviators at the National Air Races in Chicago on September 1, 1930; and press notices about the accident stated that 0.47% carbon monoxide saturation was found in this pilot's blood shortly before his death. This report was a stimulus for investigation of carbon monoxide as a possible danger in aircraft and, paradoxical as it may seem, many types of airplanes were found to be poorly ventilated and consequently many flyers were being poisoned with this gas on each and every flight. The etiology of many of the headaches before mentioned then became clear. The symptoms of this poisoning vary with the concentration of the gas and the degree of blood saturation, and usually occur in the following sequence: headaches, malaise, vomiting, palpitation, dizziness, dimness of vision, loss of muscular power, convulsions, coma and death. And as it is known that carbon monoxide causes more deaths than the total of all other gases, and was found to be a hazard of flying, an existing problem presented itself for correction, and a means whereby future delinquencies of this sort could be, easily, rapidly and accurately checked and prevented.

To solve this problem Lieutenant Commander Joel J. White, Medical Corps, U. S. Navy, enlisted the help and cooperation of several other navy medical officers, pilots at the Naval Air Station, Anacostia, D. C., the officer in charge of the engine section of the Bureau of Aeronautics, Navy Department, and the Mines Safety Appliance Company of Pittsburg, Pa. The result of his work and experimentation was the carbon monoxide indicator. This instrument consists essentially of a battery powered small motor driven positive pressure air pump; a canister of calcium chloride and active alumina, a cell containing a catalyst (hopcolite); a series of thermocouples in the catalyst cell, and an indicating meter. The meter is calibrated in hundredths of per cent carbon monoxide and has a scale range from zero to 0.15%.

The instrument is made up into the fixed and portable types of which the latter is more practicable in testing aircraft, as it can be carried about easily, and measures over all about 12 inches by 8 inches by 10 inches.

The operation of testing any given space or airplane slip stream is accomplished by turning a switch to "ON" position and the air pump draws the air into the instrument. A sampling or flexible tube may be used to carry on the tests. The air being tested comes through a manometer or flow meter and then through the canister or drying agent (as all moisture must be removed before the air is tested) and on to the catalyst cell where the carbon monoxide is oxidized to carbon dioxide by the catalytic action of the hopcolite. This hopcolite is composed of manganese dioxide and cuprous oxide especially prepared, and its action is selective for carbon monoxide only, and will not oxidize any other combustible gas under 212°F. The heat

liberated by the oxidation of the carbon monoxide is directly proportional to the amount of this gas in the air being tested, and is measured by the thermocouples and recorded on the indicating meter in the per cent of carbon monoxide.

With this indicator large numbers of various types of airplanes as well as the two Navy dirigibles were tested. The results obtained were variable, as the readings were negative in certain types of planes and as high as .035% carbon monoxide in other quite similar types. In airplanes where the percentages were found to be as high as .02 to .03% carbon monoxide, samples of about 6-8 cc. of the pilot's blood after four hours' flying showed saturations of carbon monoxide as high as 15%. This saturation although not sufficient to render a person unconscious and be the direct cause of crash, is nevertheless a high enough degree to cause definite symptoms as headache, malaise, and nausea, and if persisted in from day to day will show demonstrable signs of deterioration of the pilot's physical well-being.

The saturation of the blood with carbon monoxide was tested by the pyrotannic acid method in which blood being tested was compared to known standards of blood saturated from 100% down the scale to 5%.

In the types of planes where carbon monoxide was shown to be a definite hazard to the planes' occupants it was a comparatively simple and inexpensive modification to correct the exhaust stacks or manifolds or make minor changes in the engine or fusilage cowling and thereby obviate the presence of carbon monoxide in the cockpits.

The definite findings of carbon monoxide in certain types of aircraft and the fact that it can be readily eliminated has resulted in a change of naval aircraft specifications of all new airplanes. They must be factory tested and found free from carbon monoxide in the cockpit and other enclosed passenger-carrying spaces before delivery can be made.

In the Navy dirigibles a similar problem was found and has been corrected. The living spaces of these ships are heated by currents of air over the exhaust manifolds of two engines. The danger here was from leakage of exhaust gases, and to guard against this, fixed carbon monoxide indicators were installed that are constantly testing the air, and an automatic alarm system was incorporated with it which flashes a red light and sounds a buzzer when carbon monoxide contamination takes place.

The field of preventive medicine in late years has been broadened and acknowledged with and into nearly all lines of human endeavor. The problems of aviation medicine are nearly entirely made up of measures to make flying safer for pilots and passengers whether commercial, private or military. The inter-relation between prevention of airplane crashes and prevention of those physically unfit and temperamentally not adapted to fly must be accepted as an existing problem in practical preventive medicine. To that end the three phases of aviation medicine herein discussed are all preventive medicine measures, first, the selection of prospective pilots, becomes actually the prevention of the physically unfit and temperamentally not adapted from being our aviators; second, the establishment that certain physical phenomena peculiar to aviation do not tend to prevent or limit its development; and third, the detection of flying hazards and their control and certain future prevention. These aviation medical problems and their full understanding have a distinct and direct bearing upon safer and better flying.

* * * * * * *

(Opinions or assertions contained herein are the private ones of the writer and are not to be construed as official or reflecting the views of the Navy Department or the Naval Service at large.)

DISCUSSION

Dr. Ralph N. Greene, Jacksonville:

Doctor Iverson has simply given you a brief insight into a most interesting phase of medical activity—the application of a lot of specialists to study a presumably healthy group of individuals.

If aviation medical efforts were only applicable to aviators they probably would not be worth the very widespread interest and consideration given to flying service. But aviation medicine has made a vast contribution to the general field of medicine and surgery. On the one hand, you remember the outstanding work of Dr. H. Marshall Taylor in which he details the effort that man has made to transform himself from a terrestrial animal to an acquatic animal, likewise adjustment must be made if man is to transfer himself to an environment of celestial existence.

The aviation flight surgeon does not presume to say, except upon conjectural basis, just what an individual's reaction will be in an emergency. It has been stated by Major Logan, outstanding authority on the psychological aspects of flying, that even though a pilot's life be at stake it is difficult to foretell what his reaction will be. However, the flight surgeon can in a very definite way tell if a given individual is absolutely unfit for flying. However, the fact remains that in spite of his careful studies a certain number do not react satisfactorily to the environment, but develop some neurotic condition because of the general atmosphere structure that surrounds them.

I am sure that aviation medicine is affording a most fruitful field for medical development, and is also affording a great economy in the program of teaching people to fly.

We have a great interest in this country in the civil aspects of flying which differ somewhat from the military. Due to the expense of training aviators, the Government of course has a right to expect a number of years of active service from a pilot. In regard to civil aviation, it must be said that the standards, particularly as to night flying, have been very materially changed.

Time will not permit me to go into detail; however, I will say that it has happened only recently that I saw a pilot who was licensed to fly, although he had diplopia. I also saw one person with a heart lesion who held a license as passenger pilot.

Flying is here to stay, and to the Board of National Defense and to the Flight Surgeons who have given so much time and effort we owe due credit for the contribution they have made to the fields of medicine and surgery.

I wish to personally congratulate Dr. Iverson for the courtesy of his presentation, and for his attention to this meeting.

Lieut. Commander Louis Iverson, Pensacola (concluding):

Please accept my deepest thanks and appreciation for the honor accorded me, a non-member of the Florida Medical Association, for the privilege of appearing on the program at your annual meeting and presenting this paper, and to particularly thank your Chairman of the Scientific Committee, Dr. Bryans, who personally extended the invitation to me.

PRACTICAL POINTS IN OSTEOMYELITIS, AS SEEN AT THE AMERICAN LEGION HOSPITAL FOR CRIPPLED CHILDREN AT ST. PETERSBURG*

PRESCOTT LE BRETON, M.D.,
St. Petersburg.

Our annual reports at the hospital for crippled children show that in Florida every year, osteomyelitis heads the list of conditions crippling our children. This disease displaces the poliomyelitis which in all northern hospitals is by far the chief offender. Here in Florida, where there never has been a real epidemic of infantile paralysis, we see only a fair number of isolated cases of this condition.

Since the writer came to the American Legion Hospital three and a half years ago, there has been admitted forty-one cases of pus infections of the bones. The table shows sites of predilection; 16 in the femur; 13 in the tibia; 4 in the pelvis, etc. In some of the patients more bones than one were involved. In one case a patella was the primary focus—a rare location. There was one case with the scapula the only focus, and one where the lumbar vertebrae were involved with other bones.

PRACTICAL POINTS

Lack of early recognition by the attending physician was a striking fact in a good many cases. Quite often the history showed the early diagnosis to be that of rheumatism; and the treatment aspirin. The late abscess had been opened by a quarter-inch incision, and the diagnosis made after Nature had extruded the first piece of necrotic bone, at which time the first x-ray was made. Extensive destruction resulted.

Many physicians are prone to call the condition tuberculous. As they are very unwilling to continue in charge, they request that this slow and tedious case be transferred to a hospital elsewhere.

Although a small number of these infections are evidently due to boils or various sources, there is no question but that the vast majority come from the throat. The organism found in most of them is the staphylococcus.

The early diagnosis, which is so important, still rests on acute onset, severe pain, tenderness located near but not over the joint, septic type of temperature, absence of swelling except per-

*Read before the Pinellas County Medical Society, April 6, 1934.



FIG. 1. Limited involvement of tibia, showing origin of disease, close to epiphyseal line.



FIG. 2. Extensive involvement of tibia. Origin of ease in shaft, close to epiphyseal line.

haps slight edema, high white count and a negative x-ray. After ten to fourteen days the diagnosis is more easily made by increased swelling, heat, a positive x-ray, and a high white count.

With late diagnosis and inefficient drainage the disease may spread by blood stream to many other sites—as for example in case No. 12. In this case, extension took place from the right femur to the right knee joint, right astragalus, left tibia and fibula, left femur and ulna, jaw and spine. A good example of the value of early diagnosis is in No. 28. In this case four early openings and drainage certainly saved a life and also saved the involvement of the entire marrow cavity of the femur. The first osteotomy was a few days after the onset, when the temperature was 106; no pus was found in the neck of the femur, but the culture showed streptococcus. When the report of the culture was in, a wide opening was made into the neck through the trochanter and two inches of marrow were opened, as pus showed as grayish spots the size of a head of a pin. As the fever kept high and hip motions were painful, a drain of the hip joint was made through the buttock. After some weeks when the fever had subsided the main wound was cleaned and smoothed. At present the wounds are healed; the patient is going to school with a limp from limitation of hip motion.

In the case just mentioned the original site was the neck of the femur, and in this condition there is difficulty in distinguishing osteomyelitis of the neck from primary suppurative arthritis of the joint. Arthritis needs joint drainage through the gluteus back of the trochanter

(Ober's operation). Disease of the neck needs drill holes through the trochanter up into the neck short of the epiphyseal line. One guide may be the x-ray and another the fact that primary suppurative arthritis is rare. In this list, we had one case of arthritis of the hip, and six of osteomyelitis of the neck of the femur.

Repeatedly the point so well emphasized by Prof. Starr of Toronto was illustrated: namely, that while tuberculous infection regularly starts slowly in the epiphysis of the long bones, osteomyelitis starts suddenly on the diaphyseal side of the epiphyseal line. This line usually protects the neighboring joint from secondary infection. However, in some joints the capsule attaches itself beyond the epiphyseal line, as in the hip, so that infection can break through from shaft to joint. In four of my cases, infection did this, and riddled the joint.

Among the complications in this series of 41 cases may be mentioned:

1. Temporary facial palsy due to packing in case 18 where three sequestra were removed from the ramus of the lower jaw, well above the angle.

2. In three cases (Nos. 5, 9, and 17), fractures occurred, in the femur, clavicle and tibia. All of these united, but after quite a lapse of time.

3. There were two dislocations; of the hip in No. 2, and of the knee in No. 12. These were fixed and irreducible from inflammatory changes.

4. There were two amputations in hopeless cases; one of the foot in No. 3, where cavities riddled the foot from toes to the back of the os calcis; and one at the thigh in case 12, where the lower extremity was beyond repair.

5. There were no deaths, although several of these children were extremely septic for a long time, needing transfusions and other heroic measures.

6. There was one case of primary suppurative arthritis. This had remained a closed abscess in the hip for two months. The joint was irrigated for fifteen minutes with weak bichloride then salt solution; four loose pieces of cartilage and bone were removed and the joint closed. Culture staphylococcus. This boy is still in the hospital and recently needed further drainage.

7. In two cases, Nos. 27 and 30, where the cavity represented a circular hole of some size, a condition which Nature fills in poorly, the thinner side of the wall was resected, to allow collapse of the soft tissues and a firm healing.



FIG. 3. Origin of disease in neck of femur, spreading to involve joint, and head and shaft of femur.



FIG. 4. Osteomyelitis, originating in the neck of each femur.



FIG. 5. Osteomyelitis of the os calcis.



FIG. 6. Central abscess; one side of the cavity was removed.

rapidly and seem to drown in the pus. The technic is tedious and uninviting, and the writer has discontinued it. Probably the manufacturers have a better way to transport them than before.

Recent articles on the bacteriophage are of great interest and open up visions of wonderful progress. Let us hope that the biologists and technicians will solve this problem and give us a real and ready cure for infection.

As the writer has seen recurrence of osteomyelitis in cases healed for thirty, forty and fifty years, it is unsafe to call any of these cured. It is better to say they are arrested, just as we speak of tuberculous cases. Bacteria can live and lie dormant in scar tissue indefinitely, then awaken to raise a large family.

Many of the worst cases, after a prolonged convalescence, win back every evidence of general good health. One must never relinquish hope and patience, unless the lesion is in the deep pelvis or other inaccessible point, where direct attack is impossible and the discharge continues for years.

TREATMENT

The usual procedures were followed: in the early case, incision of the periosteum, drilling of the end of the bone and marrow cavity, excision of enough bone to give drainage; in the older case with sinuses, "unroofing" of the cavity, removal of sequestra and curetting until clean, "saucerizing" of the edges to bevel the opening, vaseline pack, dressing and a plaster cast.

This procedure follows the Orr plan, and saves untold pain from frequent dressings with dry gauze and no cast. The transition of the child from his painful nights to calm sleep is very striking. Expense is saved by infrequent dressings and dismissal from the hospital. When the odor is bad and the cast wet through, a window can be made and the outer dressings, but not the packing, removed.

The writer has tried maggots but had this experience two years ago. Home-made maggots, accidental and uninvited, are healthy and fat and leave red clean granulations. Expensive maggots from New York are small and weak, die

FIG. 7. Central abscess; one side of the cavity has been removed.



TABLE OF CASES OF OSTEOMYELITIS

Sex	Age	Stage	Location	Operation	Complication	Result
1 male	13	Chronic	Left tibia, right femur and humerus	Several	Lues treated	Healed
2 male	9	Chronic in bad condition	Neck of each femur	Several (transfusion)	Left hip dislocated	Healed
3 male	15	Chronic	Right foot, hip and rib	Amputation right calf		Artificial leg
4 male	16	Chronic	Left femur	Resection one wall of cavity		Healed
5 female	11	Chronic	Left femur; right fibula	Usual	Greenstick fracture	Healed
6 female	13	Chronic	Right femur	Usual		Healed
7 male (Col)	14	Chronic	Right radius	Usual		Healed
8 female	5	Chronic	Right tibia	Removal most of shaft		Healed.
9 male	14	Acute	Left tibia	Drainage; later osteotomy	Fracture below knee	Healed
10 female	7	Subacute; in bad condition	Necks of right and left femur; right radius and clavicle	Several with transfusions	Bedsores; long illness	Healed; limited motion in hips
11 female	3	Subacute	Left astragalus	Usual		Healed
12 female	15	Chronic; in bad condition	Right femur; knee; astragalus; left fibula and tibia; left femur, ulna and jaw; 3rd and 4th lumbar vertebrae	Several; amputation right thigh	Dislocation of right knee	Healed except left tibia; artificial leg; at school
13 female	8	Chronic	Right fibula	Usual		Healed
14 male	5	Chronic	Both tibiae	Several		Healed
15 male	9	Subacute	Right tibia	Several		Healed
16 male	16	Chronic	Right femur; neck of left femur	Several	Stiff joint	Sometimes reopens
17 female	16	Chronic	Left clavicle; right ilium	Usual	Fracture of clavicle	Healed
18 female	10	Chronic	Left side of jaw above angle	Usual	Temporary palsy facial from packing	Healed
19 male	16	Chronic	Neck, left femur	Usual	Hip not involved	Healed
20 male	4	Subacute	Left pubis; rami	Usual, through the adductor muscles		Healed
21 female	15	Chronic	Left femur	Several		Healed
22 female	1	Chronic	Left tibia	Several		Healed
23 male (Col)	13	Subacute	Neck of right femur and joint	Usual		Discharged with drainage and stiff joint
24 female	13	Chronic	Right femur (trochanter)	Usual		Sometimes reopens
25 female	1½	Subacute	Right scapula	Usual	Abscess in axilla	Still has drainage
26 male	6	Acute	Left tibia	Usual		Healed
27 female	11	Subacute	Right ilium	One wall of cavity removed		Healed
28 male	13	Acute–very ill	Neck of right femur; joint (strep)	4 operations	Limited motions	Healed
29 female	15	Chronic	Ring finger	Joint excised	Abscess in soft tissue forearm	Healed
30 male	14	Chronic	Left femur	Excision one wall of cavity		Healed
31 female	9	Acute	Right patella left knee joint and tibia	Several	Limited motion each knee	Left tibia draining
32 male	15	Acute	Abscess left hip joint (staph.)	Several	Limited motion of hip	In hospital
33 female	16	Chronic	Left femur	Several		Healed
34 male	16	Chronic	Left tibia	Usual		Healed
35 male	10	Chronic	Os calcis	Usual		Healed
36 female	4	Subacute	Right trochanter	Usual		Healed
37 female	11	Chronic	Metatarsals	Usual		Healed, still in hospital
38 female	16	Chronic	Tibia	Usual		Healed
39 male	15	Chronic	Humerus and elbow joint	Usual	Stiff elbow	In hospital
40 male	12	Chronic	Left tibia	Usual		In hospital
41 male	3½	Chronic	Right tibia	Usual		In hospital

BRONCHIAL ASTHMA*

R. L. Cline, M.D.,
Lakeland.

I am aware that when the profession as a whole has a thought of asthma it is in terms of allergy. I am also aware that what I have to say is at variance with the conventional idea of the profession. In this paper I am dealing only with facts establishing the basis of bronchial asthma.

In 1900, James Adam of Glasgow, Scotland, wrote an article in which he put forward a view that asthma is a result of two underlying basic factors—a chronic systemic toxicosis and a lesion in the upper respiratory tract, most commonly located in the nose in the ethmoid area, or it may be anywhere within the confines of the sensory nerve terminals of the fifth, ninth and tenth nerves. These ideas were again elaborated in his post-graduate lectures in 1910, and in 1913 he published a book which received little attention and finally fell by the wayside, only to be resurrected by the attention of Burton Haseltine in America. In 1927 this book received the compliments of no less authority than Chevalier Jackson as the most helpful book ever published on asthma.

The following are some facts which gave to Adam the thought that asthma has for its basis a lowered metabolism and a resulting toxicosis:—that laboring asthmatics often go into a broncho-spasm during week ends while lounging around with overloaded stomachs, attacks occurring around 4 a. m. Monday morning, the time of metabolic cessation, the acid tide. They are spontaneously relieved upon their return to labor when their elimination and metabolism in general are increased. Again, the draft horse goes into the asthmatic stage after a hard week's work followed by confinement in his stall with a too full stomach, the attack siezing him around 4 a. m. Monday, the acid tide, and again is relieved when placed back in the harness. Further, the pampered Englishmen with habitual asthma, when necessity forced them into the army with hard work and none too liberal diet, often overcame their asthma, only to have it return after the war while again living their lazy lives. We have yet more evidence in the fact that asthma is rare in the Negro, the Eskimo, and the American Indian for similar reasons, namely, that they must earn their bread by the sweat of their brows. There is a greater percentage of asthmatics where there is only one pampered child in a family; also city folks are more subject to asthma than country people who are exposed to fresh air, sunshine and regular activity and work. Asthma is rare in the dog, save the pampered house dog, and in the bird kingdom it occurs only in caged birds.

In 1903 Brodie and Dixon, two English physiologists, presented before the Pathological Society of London results of carefully planned scientific animal experimental studies on bronchial spasms and definitely proved a neuro-anatomical connection, reflex in character, between the bronchioles and the sensory nerve terminals of the upper respiratory tract. These findings have later been demonstrated in animal experimental work by numerous other workers. Since we know that the immediate inciting cause of the broncho-spastic storm is usually a stimulus to the vagus from a peripheral source, we have a great clinical help in finding and removing this exciting cause. There is complete agreement here in the evidence coming from four different sources of information: (1) anatomically, there is a close connection between the fifth and vagus nerves, the experiments of Brodie and Dixon above referred to; (2) it is further demonstrated by being able to subdue the broncho-spasm by cocainizing the fifth nerve in the nose; (3) pathologic areas are found in the ethmoid area of most asthmatics; (4) the correction of which results in the diminution and almost always complete cessation of the spasm.

Following up the animal experimental work of Brodie and Dixon, Kenneth Phillips of Miami, in 1933 produced asthma in the living dog. He produced the systemic toxicosis in three ways; first, by producing intestinal isolated loops; second, by removing the parathyroid glands and castration; third, by removal of the adrenals. After the systemic toxicosis was produced, the ethmoid area was then injured and a purulent infection set up. The dog in due course of time developed bronchial spasms which could be controlled by cocainizing the lesion in the ethmoid area or by removing the isolated loops, thus controlling the systemic toxicosis. I had the privilege of observing this experiment personally.

Unaware of the findings of Adam, Brodie and Dixon, Burton Haseltine, of Chicago, twenty-eight years ago began a study, and the slowly unweaving results of his work and observations in a logical construction for the basis of asthma. As time went on, he was joined in this work by

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LaForge, Waterman, Fitzpatrick, Kern, Dean Myers, and more recently Kenneth Phillips. After twenty-five years these early investigators from three-quarters of the globe had independently come to the same conclusion. Eight years ago a group of these workers, including Haseltine, met in Europe and devised and revised one of the most valuable pieces of work in medicine; and today the asthmatic patient can be handled with precision, yielding results the same as other diseases of known etiology and treatment.

To my mind this conception of asthma is marvelous, yet a greater marvel lies in the fact that after more than a quarter of a century the profession has not accepted it. I could not understand why it had not been accepted and while on a visit to Haseltine's office a couple of years ago I asked him why, and he answered in one short sentence, "There is nothing to sell." Had there been a medicine to cure asthma it would have been manufactured, exploited, and covered the face of the earth before breakfast.

The outstanding fact is that in the therapy of these unfortunate patients, nothing need be done that would not be indicated for their physical welfare even though they were not asthmatic. First and foremost in this conception of the nature of asthma is the fact that all these patients are systemically abnormal, sick, chronically toxic. These studies point clearly to the fact that allergy is an effect, not a cause; that anaphylaxis is an effect; that hypersensitiveness is an effect; that disturbance of endocrine functions is often an effect; that asthma itself is an effect; and that the cause of all these is toxicosis. This condition may be bacterial or non-bacterial; it may be exogenous or endogenous; the mere dysfunction of the channels of elimination may produce it. Whatever the cause, it must be eliminated to overcome asthma. In the asthmatic this toxic state, according to the technique of Clifford Mitchell, of Chicago, may be demonstrated by blood and urine findings; the same findings may be demonstrated in other chronic toxicosis, whether the patient be asthmatic or not.

A bronchial spasm may be produced in a chronically toxic patient by mechanically exciting the vagus nerve. If he be not toxic such excitation would produce only a cough or sneeze. Many patients are potential asthmatics, though they may not have the broncho-spasm, yet they might have should they by chance develop a lesion to the vagus system.

Therefore, asthma is a by-product, a syndrome characterized by certain symptoms, one of which, and the most outstanding, is the bronchial spasm. This toxic condition is due to improper balance between the amount of toxic material engendered within the organism and absorbed by it and the amount of such material removed from the organism by the natural channels of elimination. It is also a fact that when this improper balance is corrected, by lessening the absorption or increasing the elimination, or by both, the toxicosis tends to disappear and the asthmatic syndrome diminishes in severity. This diminution of toxicosis can be demonstrated by laboratory findings.

The asthmatic is also subject to one or all of the following: urticaria, eczema, erythema, vomiting, food or other sensitizations, hyperesthetic rhinitis, hayfever, angio-neurotic edema, and, as Phillips has determined, liver dysfunction.

It must not be supposed that the terms toxicosis and allergy are synonymous. The toxic condition is the factor underlying all the asthmatic manifestations, while only about one-half of the asthmatic cases can be shown to be allergic. Allergy is only one of the symptoms of the toxicosis and like all others tends to disappear with detoxication. The adherents to the allergic theory wonder why an individual may be sensitive to a certain protein today and tolerant tomorrow, or why other individuals are never sensitive. The one is sensitive because of his systemic disturbance, metabolic, toxic, endocrine, or whatnot.

Chapagrell of New Orleans, a pioneer in allergy, relates in his book published in 1922, of a man, 45 years of age, who had lived on a Mississippi farm all his life and after having pulled fodder in a corn field one September afternoon, when the field was alive with ragweed pollen, came down that night with intolerable asthmatic symptoms, though he had never shown such symptoms before. Nothing had gone wrong with the ragweed pollen, but something had happened to this individual. I can picture this man as having had a nasal deformity, inducing innumerable colds, leading to turgescence, hyperplasia, polyposis, pus, and as the years passed this pathological condition invaded the sinuses, they being lined with one and the same mucous membrane as the nose. This condition, producing a chronic systemic toxicosis and an irritant to the vagus nerve, with an overwhelming dose of ragweed pollen was quite sufficient to set off the bronchial spasm.

To be sure the man had become allergic. Was

he born allergic? Had it happened by chance or by magic? It happened as a result of the chronic toxicosis and laboratory findings could have demonstrated it. What is to be done about this allergy and asthma? Should he have been removed from his farm, should he have been desensitized? If that is the best that could be done, fine. Had he been removed from the farm, had he been desensitized or had he had a hypodermic of adrenalin chloride, this evil day would have been postponed, though he would still have been carrying his toxic load and sooner or later this toxic condition would have become so great and the vagus irritation so pronounced that asthma would have seized him had he never seen a ragweed pollen. Instead of removing him from the farm or desensitizing him this mechanical block and nerve irritation should have been removed, the pathology of the nose and maxillary sinus cleared up, and he detoxicated. He could then have had asthma no more; would have been allergic no more even though he lived in a ragweed field.

In spite of this information, no later than 1927 there was established in Great Britain an Asthmatic Research Council for the purpose of studying asthma, with Dr. Arthur Hearst, himself an asthmatic, as its medical head. The following year, through the influence of Dr. Hearst, a like institution was established at Guy's Hospital, London, and during the same year a third institution was established at the Great Ormond Street Hospital for Sick Children, headed by Dr. G. W. Bray. The net result of all these efforts may be summed up in the often repeated assertion of Dr. Hearst—that the status of asthma is thus far a hopeless and helpless one and the most the profession can do is to relieve the symptoms and steer these unfortunates clear of the will-o-the-wisp "cures."

In conclusion allow me to say that nearly all children and young adults can be cured of asthma, that the majority of those above 35 years of age can likewise be cured. This statement is based on the clinical reports of over 3,500 cases from the clinics of Adam in Europe, Haseltine in Chicago, and Phillips in Miami. Asthma is essentially due to two underlying basic factors, a chronic systemic toxicosis together with a lesion of the upper respiratory tract and so perfectly as these two factors can be overcome just so perfectly can every asthmatic be cured.

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THE VALUE OF THE HORMONES AS DIAGNOSTIC AGENTS*

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Before considering the newer developments which led to the Ascheim-Zondek test, it is well to review briefly the changes which take place in the pituitary gland during pregnancy. During pregnancy the anterior portion of the pituitary gland undergoes marked changes. Comte was the first to describe the enlargement of the gland, especially the anterior lobe. The most exhaustive investigation of this subject was published by Erdheim and Stumme in 1908. They reported their findings in a series of 150 pituitary glands. A confirmation of these results was published by Kolde in 1912. The increase of volume of the pituitary, according to these writers, is two and one-half times the normal weight, in actual weight 1.06 grams. After removal of the brain at autopsy the gland protrudes markedly from the sella turcica. By radiological examination one can find a deepening and a pressure atrophy of the floor of the sella turcica or a widening of the opening. As a result of this enlargement of the pituitary gland, changes have occurred which have been described as the acromegaly of pregnancy.

According to Williams, it has been suggested that the nonedematous swollen features of the face as well as of the extremities seen in pregnancy have some distinct relationship to the activity of the pituitary gland during pregnancy. Pressure symptoms have been described upon the optic chiasma and brain, bitemporal hemianopsia, optic atrophy, cerebral symptoms. Erdheim and Stumme state that with this enlargement and

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increase in weight, the gland has a more rounded contour and the vessels are dilated and congested. On section of the pituitary gland, it presents a homogenous grayish-white color, instead of its normal red-gray color. It appears more succulent and from it can be expressed a milky fluid. These changes are found almost entirely in the anterior lobe. The changes in the histology of the gland are just as striking as these gross characteristics. They consist chiefly in the disappearance of the eosinophilic cells, which are predominant under ordinary circumstances, and the replacement of these eosinophilic cells almost entirely by the so-called chief cells.

The anterior lobe of the pituitary produces two hormones, namely prolan A and prolan B. These hormones are so named by Ascheim and Zondek. Prolan A acts on the primordial and the mature follicles with the development of a liquor folliculi which is the source of the hormone known as theelin. Prolan B stimulates the corpus luteum to grow into its characteristic lutein cells. Prolan B is the hormone that is found so abundantly in the urine of pregnant women and is the one which brings about the luteinization of the ovary in the test animal.

In the development of the adult endometrium there are three stages, namely: the early interval, the midpremenstrual and the active late secretory or menstrual period. Theelin has an effect on the endometrium to the extent that it can produce the change up to the midpremenstrual stage, but theelin by itself cannot bring about the characteristic picture of the endometrium late in the premenstrual period. The corpus luteum hormone of the ovary cannot produce the changes exhibited by theelin, but when used in conjunction with theelin, can bring about the change which is seen as the most exaggerated picture of the premenstrual phase.

Thus we can see that the Ascheim-Zondek test isdependent upon the prolan A and prolan B for its reaction. Since prolan A and prolan B are derivatives from the anterior pituitary gland, this reaction is sometimes known as the anterior-pituitary reaction, or APR.

As far as our present clinical investigations have been developed, this APR reaction is of definite diagnostic value in pelvic masses, be they tumor masses or malignancies.

The clinical as well as the histologic diagnosis of chorio-epithelioma has in the past been difficult and often impossible until the possibility of a cure has been precluded by local or distant metastasis. With the advent of the hormone, however, a method has been evolved which assures the early recognition of this highly malignant tumor.

The presence of prolan hormone in the urine in increasing amounts longer than two weeks after the termination of a normal pregnancy, whether premature or at term, or longer than two months following the expulsion of a hydatiform mole is strongly indicative of chorionepithelioma. Likewise the reappearance of a positive reaction following one or more negative reactions is indicative of malignant degeneration. Conversely the presence of the prolan hormone in steadily decreasing amounts is strong evidence against a malignancy.

For example, suppose we have a patient who proceeds to bleed longer than we expect following a normal delivery, say over two weeks, or one in whom irregular bleeding occurs. An Ascheim-Zondek test could be used to good advantage. A positive reaction means either an attached viable portion of the placenta or a beginning chorionepithelioma. A negative reaction means no malignancy and no viable placental patches, but probably detached non-viable unexpelled portion of placenta or membranes.

Since a relatively large number of patients who have had hydatiform mole will eventually develop chorionepithelioma, careful study of these patients is indicated. In these cases weekly estimations of the concentration of prolan should be made until the reaction becomes negative. A negative reaction is clear evidence against the presence of chorionic tissue, an increasing concentration of prolan or the reappearance of a positive reaction is indicative of malignancy.

The following materials are used in the Ascheim-Zondek test:

(1) A 1000 to 1500 gram rabbit, female, virgin, preferably three months old.

(2) One cc. of blood serum of the patient for each 600 grams of the body weight of the rabbit.

(3) Serum should be at least six hours old. If given to a rabbit before six hours will produce anaphylactic reaction and kill the rabbit.

The serum is given in the above proportions in the vein of the ear of the rabbit. The serum hormone will keep for six or eight days with ease. The test will be positive even before the period

is missed or the patient knows she is pregnant. This particular point is well to remember because ectopic pregnancies may, and often do, occur in the isthmus and interstitial portion of the tube and it is here that they may rupture much earlier and are more dangerous. An interstitial tubal pregnancy can rupture between menstrual periods without a skipped period. The test will remain positive for eight days after cessation of labor or death of the fetus and will, except in cases of malignancy, be negative thereafter.

Up until 1930 no reference could be found in the literature on the use of blood serum in rabbits for the Ascheim-Zondek test. Apparently absorption of the hormone from the anterior lobe of the pituitary is directly through its vascular supply. Therefore it seems rather logical to expect a more constant level of the hormone in the blood serum since any excess may be liberated through the kidney.

The presence of the anterior pituitary hormone has been demonstrated in the decidua, corpus luteum, placenta of ectopic pregnancy, cord blood of pregnancy of four months and in the cord blood of a full term pregnancy. The peculiar thing is that the hormone is not found in the spinal fluid.

When equal amounts of urine and serum were given to rabbits of the same weight and the tests allowed to run for the same interval of time, the contrast was very marked, the reaction from the serum being about twice as strong as the reaction from the urine.

TYPES OF REACTION IN THE RABBIT OVARY

The reaction is either positive or negative. The test is negative if the ovarian tissue is normal. In case of an emergency, if blood serum is used, autopsy of rabbit will show one or two follicular enlargements in twelve hours.

Positive reaction may be:

(I) Weakly positive, just developing, with or without hemorrhage of follicles in ovary, looks like tapioca pudding.

This is seen in:

(1) Pituitary tumors.

(2) Ovarian cysts.

(3) Essential amenorrhea.

(4) Phantom pregnancies.

(5) 30% of cancers in the body tissues anywhere.

(6) 70% of cancers in the genital tract.

(7) Tumors of the testicle, more especially teratomata.

(II) Strongly positive, showing blood points or hemorrhage in ovarian tissue, indicating:

(1) Pregnancy.

(2) Hydatiform mole.

(3) Chorionepithelioma.

The latter two give a much stronger reaction than ordinary pregnancy.

(III) After 100 hours will show definite formation of corpus lutea in rabbit's ovaries.

SUMMARY

(1) In the present modification of the Ascheim-Zondek test, 2 cc. to 5 cc. of serum is used.

(2) It is allowed to stand for six hours and injected into the ear vein of a virgin female rabbit.

(3) The average amount of serum used is one cc. for each 600 grams of body weight of rabbit.

(4) Animals weighing from 1200 to 1500 grams give the most constant results.

(5) The rabbits may be operated upon for diagnosis in 12 to 30 hours.

(6) The rabbit can be used again in three weeks.

(7) The reaction of the blood serum intravenously is definitely more marked and appears in a shorter time than when urine is used either intra-abdominally or intravenously, the reaction by use of blood serum intravenously being observed more definitely in the gross and appearing in about one-fourth to one-third the usual length of time.

(8) The value of this prolan hormone is of definite value in following the course and metastasis and gauging the x-ray treatment of chorionepitheliomas and teratomas.

(9) The value of this prolan hormone is of definite value in differential diagnosis between extra-uterine pregnancies and other pelvic masses.

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HERBERT E. WHITE, M.D. *St. Augustine*

DR. H. MARSHALL TAYLOR ELECTED PRESIDENT OF SOUTHERN MEDICAL ASSOCIATION

The Journal desires to express its pleasure in the selection of a Florida physician, Dr. H. Marshall Taylor of Jacksonville, as President of the Southern Medical Association for 1935. This organization, the second largest medical society in the world, draws its membership from sixteen states and the District of Columbia. That so large and important a body should choose two of its twenty-seven presidents from Florida with its comparatively small resident population rather than from more thickly populated states, is a pleasing commentary on the high type of physician practicing in this state. In 1912 the Southern Medical Association turned to Florida for leadership when Dr. J. M. Jackson of Miami became president. In conferring the honor upon Dr. Taylor this Association again compliments the personnel of our state Association and at the same time gives fitting recognition to an able physician and enthusiastic worker for organized medicine both in his home state and throughout the country.

For many years Dr. Taylor has been most active in our Association. He has been diligent in attending its meetings and has presented a number of papers before his Section on Otolaryngology. In 1923 he served as president. He has led in promoting the medical legislation we have fostered, especially that pertaining to the proper labeling of commercial products which, if taken by mouth, might result in strictures of the esophagus. It was through his efforts that Florida was one of the first four states to require the placing of proper labels on lye products that children might be safeguarded. For a number of years he represented Florida in the House of Delegates of the American Medical Association.

Despite the exactions of a very large private practice, Dr. Taylor has found time to serve his county society as well as our state organization in an official capacity. In 1930 he was President of the Duval County Medical Society. In Jacksonville, the city of his choice, he is on the staff of the Duval County Hospital, of St. Luke's Hospital and of Riverside Hospital and in nearby St. Augustine he is consulting otolaryngologist to the Florida East Coast Hospital and to the State School for the Deaf and the Blind. He is an indefatigible worker but is always able to find time from his heavy duties to devote to the activities of his colleagues in providing improved care for the sick. He is one of the outstanding physicians of his city and state and has a keen interest in all branches of the profession and in the welfare of the public.

Although Dr. Taylor is not a Floridian by birth, he has spent his entire professional life in Florida. Reared in Virginia, he received his early schooling in Lexington, his college training in Richmond and his medical education at the Medical College of Virginia and at Emory University. After two years of special training at the New York Eye and Ear Infirmary, he was for some time associated in practice with the late Dr. C. D. Coakley. Later he studied in the clinics of Paris, Vienna and Munich. In 1912 he located in Jacksonville.

His thorough training and wide experience are reflected in his writings. They show his interest in a diversity of subjects and display his flair for the original. With that investigative turn of mind which is innate in the true physician, he has pioneered in unusual fields of research. He is an authority on the problems of public bathing pools and on the hygiene of swimming as demonstrated largely through comparative anatomy. His observations on their relation to sinusitis and otologic conditions merit the wide notice which they have received both in professional and edu-

cational circles. Recently he has observed and reported some effects upon the fetus of quinine administered to the mother.

In an editorial in the January issue of the Journal of the Southern Medical Association which pays tribute to its new president, there appears a biographical sketch of Dr. Taylor and in addition a bibliography of his contributions to medical literature. In an official capacity he is no stranger to this organization which he now heads. He served first as Secretary and then as Chairman of the Section on Ophthalmology and Otolaryngology. Also, he was a member of the Council for six years, the last two as Chairman. The Journal heartily commends the wisdom of the Southern Medical Association in selecting a physician of Dr. Taylor's attainments and broad culture for its president for 1935 and very genuinely appreciates the recognition given Florida doctors by selecting one of their number for this high honor.

GASTON HOLCOMBE EDWARDS

Death has taken a most beloved member of the Florida Medical Association. Gaston Edwards passed away December 29 after a brief illness. He was an indefatigable worker in every worthwhile phase of life. For many years he served our Association as an officer and committeeman. In 1931, he was elected President of the Association. He also served in the following capacities: chairman of Committee on Scientific Work; chairman of Committee on Publication; member of Executive Committee; chairman of Council; associate editor of Journal; and delegate to the House of Delegates of the American Medical Association. Few meetings of the Association passed without the cheering and enthusiastic influence of Gaston's presence.

Dr. Edwards was born in Granby, Conn. in 1875, the son of Dr. George W. Edwards and Ann Eliza Holcombe. He received the degree of Ph.B., M.S., and M.D. from the Sheffield Scientific School and Medical School of Yale University. After two years' hospital service in Kings County Hospital in New York, he spent a year of travel in the West Indies and South America. He was in the medical service of the United States government from 1906 to 1909 in the Canal Zone, Panama, acting as surgeon for two years at the Colon Hospital at Colon, Panama.

Locating in Orlando in 1909, Dr. Edwards began the practice of medicine and in 1914 he formed a partnership with Dr. John S. McEwan. Together they organized the Orlando Clinic. In 1918 and 1919, Dr. Edwards served with the American Red Cross, acting as deputy commissioner to Serbia, with headquarters in Belgrade. He was decorated by King Peter with the third order of St. Sava and the Serbian Red Cross. For refugee work in Macedonia, he was made a member of the Order de Lutra. For service in France, he received the French "Medaille Commerate."

Dr. Edwards was a Fellow of the American College of Surgeons, a Fellow of the American Medical Association, Southeastern Surgical Association, Southern Medical Association, a member of the Florida Medical Association and the Orange County Medical Society.

He is survived by his widow, Adair Irwin Dunn Edwards, and three children, Mary Adair Edwards, George W. Edwards and Warren Hardin Edwards.

In an editorial appearing in the *Orlando Sentinel-Star*, December 30, the closing paragraphs read as follows:

"A big man, and at one time, a rich man, but never too big, nor too busy, nor too wealthy to stop and help along his fellow man.

"A good citizen, he was active in service clubs, headed the utility commission and was a yeoman in the vanguard for his city. But others could be these things—and still fall far short of being a man.

"Edwards loved people. He never lost sight of them and their problems.

"Like the oaks he loved, strong and sturdy, his character embraced their attributes. He bothered not about the wee things of life, but he reared his head into lofty clouds; always ready to forgive the frailties of man.

"In the words of Walter Savage Landor:

"'I strove with none, for none was worthy of my strife;
Nature I loved, and after Nature, art.
I warmed both hands before the fire of life:
It sinks, and I am ready to depart'".

PRE-CONVENTION MEETING

Dr. Homer Pearson, President, after action of the Executive Committee, has announced that the Pre-convention Meeting of the Florida Medical Association will be held at Orlando, Thursday, February 7, 1935. The San Juan Hotel has been designated as headquarters for this meeting. The guest speaker for this occasion will be Dr. Walter L. Bierring, President of the American Medical Association, who needs no introduction to our members, as he is a familiar figure in Florida.

The program for the Pre-convention Meeting follows:

1:00 P.M.—Councilors' Dinner.

Councilors are requested to bring written reports which will be read at this dinner conference. All members of Florida Medical Association are privileged to attend this 1:00 o'clock meeting.

5:00 P.M.—General Session.

All members of Florida Medical Association are invited. Committees desiring to make brief reports will be heard and any other business of interest to the gathering may be taken up.

6:30 P.M.—Address by Dr. Walter L. Bierring, President of the American Medical Association.

7:00 P.M.—Buffet Supper.

Furnished by Orange County Medical Society.

* * *

Instructions to Committee Chairmen

Please arrange a meeting of your committee for some convenient time, not in conflict with the above schedule. Notify Dr. Meredith Mallory, Box 1011, Orlando, at once, the time of day your Committee will meet. This is very important as Dr. Mallory will need advance notice in order to arrange private rooms for committee meetings. Notify your Committee members of the time and place of your Committee meeting.

* * *

Notice!

All officers, committeemen, and councilors are expected to attend this Pre-convention meeting.

Considerable confusion arose when setting the final date for this Pre-convention meeting owing to circumstances in connection with the date suitable to Dr. Bierring. *This notice cancels all previous communications* with regard to the date which has now been set by the Executive Committee as Thursday, February 7, at Orlando.

IMPOSTOR APPREHENDED

A letter headed, "Warning, Watch for Impostors," mailed by the Association's secretary on December 18 to all county society presidents and secretaries, brought immediate results.

In this letter, members of the Association were asked to be on the watch for a man giving his name as Charles Cooper who was reported to be soliciting subscriptions to the Journal of the American Medical Association; accepting and cashing checks given for these subscriptions. According to information from the American Medical Association, this man, who was unauthorized by them, had worked in Indiana and Minnesota previous to coming to Florida.

On December 20, Doctor J. A. Pines, secretary of the Orange County Medical Society made the following report to the Association:

"Thank you for the information about our friend Charles Cooper, posing as a representative of the A. M. A. We have the gentleman in jail this morning. He was working the Orlando doctors yesterday. We had our monthly medical meeting last evening and passed the word around to our members to look out for sharks. He fell right into our trap. Quick work, I will say."

In connection with the apprehension of this impostor, a letter has been received from the American Medical Association:

"We want to thank the efforts of the physicians who brought about the arrest of Mr. Charles Cooper. He has preyed upon the medical profession for quite some time. Apparently he has worked in several states as we have had complaints from different sections of the country.

"We have notified the National Publishers Association of New York City, whose business it is to prosecute fraud agents, of Mr. Cooper's arrest as well as the agencies whose receipts were given when the subscriptions were solicited.

"If we can be of any further assistance, do not hesitate in writing us."

PRELIMINARY REPORT OF THE COMMITTEE ON MEDICAL ECONOMICS

The Committee met in Ocala on the 14th of October and again on the 9th of December, 1934.

At the second meeting, in conference with representatives of the Florida Emergency Relief Administration, the Rules and Regulations which are printed in full following this report were worked out in detail with every possible consideration for the medical profession of the state. These Rules and Regulations were then approved by the Director of the FERA, then forwarded to our Executive Committee for its approval. They became effective Jan. 1, 1935.

Certain concessions which we desired we were made to realize were impossible because of the limited funds that are, or will be, at the disposal of the FERA. We found the representatives of the FERA most reasonable, very kindly disposed toward the medical profession and appreciative of the efforts and sacrifices of the doctors. The Committee believes that it has obtained every possible consideration for the profession and that it will, under these new provisions, receive compensation fairly comparable to other professions and businesses.

We have endeavored to have recognized and definitely recorded the following facts: 1. That these fees to which we have consented on behalf of the medical profession do not remunerate it for the services rendered but that they do, being about one-half of the usual fees, approximately cover the cost of rendering the services; 2. that our acceptance of these low fees is our patriotic contribution in the existing emergency; 3. that these low fees are for the duration of the emergency only; and 4. that the traditional patient-physician relationship must be respected.

Under Regulation 9 it will be seen that mileage on country visits will be increased to ten cents per mile, each way, as soon as our State Legislature makes the expected appropriations.

The Doctor will now receive $25 for an obstetrical case that he handles in the expected manner, *i. e.*, five prenatal office visits at $1 each, the delivery at $15 and two postnatal home visits at $2 each, on the third and tenth days and an office gynecological examination at the end of six weeks at $1. The division of fees in this manner makes it unnecessary for the doctor to wait until six weeks after delivery for his entire fee. Now, also, the doctor may have a fee of $10 for his services when he finds it necessary because of some complication to refer the patient to a hospital during the second stage of labor.

For special services in the home or office, such as fractures, general anesthesia, minor surgery, the doctor will be paid 50% of the established local fee. The fee for intravenous injections is now $2 and it is unnecessary for the doctor to provide neosalvarsan or other expensive drugs for they may be had on prescription from the drugstore or from the FERA's supply depot in some towns.

Provision is also made for obtaining special materials and supplies when necessary for unusual conditions by the physician contacting the local FERA head.

Provision is made for the appointment by each County Medical Society of a "Professional and Advisory Committee" to whom the local FERA unit may turn for advice and to whom they may refer complaints of the attending physician's services. This is done with a view to leaving control, as far as is feasible and politic, of attending physicians to organized medicine.

It will be noted that there are still no provisions for fees for the care of patients in hospitals. These cases are handled as in years past. The FERA insists that they must remain the charge of the city and county authorities, as they have always been. The Committee is of the opinion that the time is ripe for beginning negotiations by the County Medical Societies with county and city administrations to secure some remuneration for the care of these indigents, and other indigents not covered by the FERA. The Committee believes that this burden should fall upon the city and county taxpayers as a whole and not upon the members of the medical profession alone. It is assumed that the FERA is a temporary organization and will pass with the present crisis but a considerable number of indigent sick will always be available for medical care. Shall the medical profession seize this opportune time to have the taxpayers assume this burden or is it one that we wish to continue ourselves?

THE COMMITTEE ON MEDICAL ECONOMICS,
HENRY C. DOZIER, Chairman;
O. O. FEASTER, Secretary;
ROY J. HOLMES,
MOZART A. LISCHKOFF,
WILLIAM C. THOMAS.

MANUAL
RULES AND REGULATIONS GOVERNING MEDICAL CARE PROVIDED IN THE HOME TO RECIPIENTS OF UNEMPLOYMENT RELIEF

December 10, 1934
(Effective January 1, 1935)

STATE OF FLORIDA

FLORIDA EMERGENCY RELIEF ADMINISTRATION
EXCHANGE BUILDING
JACKSONVILLE, FLORIDA

INTRODUCTION

The conservation and maintenance of the public health is a primary function of Government. In the present economic depression, the ingenuity of Federal, State and local relief officials is being taxed to conserve available public funds and, at the same time, to give adequate relief to those in need.

For the purpose of facilitating the discharge of these obligations with regard to medical care, the following rules and regulations governing medical care provided in the home to recipients of unemployment relief are hereby established.

CHAPTER I

STATEMENT OF POLICY

SECTION A.—DEFINITIONS. As used in these rules and regulations:

Item 1. *"Medical care provided in the home"* means medicine, medical supplies, and medical attendance furnished by a local relief administration, to persons or their dependents in their abode or habitation whenever possible and does not include hospital or institutional care.

a. It does not include medical, nursing and dental services, given either "in the home," in the office, or in a clinic, where such services are already established in the community and paid for, in whole or in part, from local and/or State funds in accordance with local statutes or charter provisions. Federal and State Emergency Relief Funds shall not be used in lieu of such local and/or State funds to pay for these established services.

b. The scope of "medical care" as above defined shall be construed to include: *Bedside nursing care,* as an adjunct to medical attendance; and *emergency dental care*—subject to the restrictions stated in the preceding paragraph.

c. "Medical care" as above defined shall be construed ordinarily to include only necessary care for conditions that cause acute suffering, interfere with earning capacity, endanger life, or threaten some permanent new handicap that is preventable when medical care is sought.

d. "Emergency dental care" shall in general be restricted to those extractions, fillings, treatments and repairs which are necessary for the relief of pain and other conditions referred to in the preceding paragraph.

e. "Medicine" and necessary drugs shall be restricted to a formulary which excludes expensive drugs where less expensive drugs can be used with the same therapeutic effect. Proprietary or patent medicines shall not be authorized.

f. "Medical supplies" shall be restricted to the simplest *emergency* needs of the patient consistent with good medical care.

g. The phrase "in the home" shall be interpreted to include medical and dental office service for ambulatory patients: Provided, that such medical and dental office service shall not supplant the services of clinics and/or salaried physicians and dentists already provided in the community.

Item 2. *"Recipients of unemployment relief"* means all cases of home relief who have been duly investigated, and found to be eligible for unemployment relief.

SECTION B.—OBJECTIVES. The common aim of the state-wide medical relief program is the provision of good medical care at a low cost to the mutual benefit of the indigent patient, professional attendant and taxpayer. This program has the following objectives:

Item 1. *Uniform Policy.* Medical care is to be provided for recipients of unemployment relief, under these regulations, in accordance with a uniform policy, formulated by the Florida Emergency Relief Administration in consultation with representatives of the organized State medical, dental and other participating professions.

Item 2. *Maintenance of Professional Standards.* This policy recognizes, within legal and economic limitations, the traditional relationships existing between the patient and physician or other professional attendant, and provides that authorized professional attendants shall furnish to recipients of unemployment relief the same quality of service as would be rendered to a private patient, with the understanding that such authorized service shall be a minimum consistent with good professional judgment, and shall be charged for at an agreed rate which makes due allowance for the conservation of relief funds.

Item 3. *More Adequate Medical Care.* a. The policy adopted shall be to augment and render more adequate facilities already existing in the community for the provision of medical care by medical, dental and nursing professions to indigent persons.

b. This policy and the scope of the program of medical care adopted locally, under the provisions of these regulations, shall be restricted to supplementation of local facilities and services, and shall imply continuance in the use of hospitals, clinics and medical, dental and nursing services already established in the community and paid for, in whole or in part, from local and/or State funds in accordance with local statutes or charter provisions or in accordance with provisions of the State Laws which require or permit services not within the scope of the Florida Emergency Relief Program.

Item 4. *Uniform Procedure.* a. In the interest of simplified administration and accounting, as well as the provision of adequate medical care at a low cost, a uniform procedure for authorization of medical, dental, and nursing care in the home shall be established by each local relief administration. This procedure shall not be in conflict with the detailed requirements stated in Chapter II of these regulations.

SECTION C.—PROFESSIONAL SUPERVISION AND ADVICE.

Item 1. *Division of Medical Care* (under the Social Service Department of the Florida Emergency Relief Administration). The objective of establishing this division is to provide additional expert supervision over medical and related problems confronted in the administration of unemployment relief and to designate either a part or full time director of medical care, who meets with the approval of the Florida Medical Association, to act as liaison officer in respect to medical problems between the State Administration, State and County professional organizations and local relief administrations and departments of health.

Item 2. *Professional and Advisory Committees.* In accordance with general policy and the recommendations of the Florida Medical Association, the appointment of State and County Professional and Advisory Committees is recommended. These committees should be freely used in developing matters of both policy and procedure in the general medical relief program.

SECTION D.—SCOPE OF PARTICIPATION. The scope of participation in the state-wide program of medical care, provided in the home to recipients of unemployment relief under the Florida Emergency Relief Administration, is subject to statutory and/or charter limitations applying either, or both, to municipal corporations or/and to professional personnel.

Item 1. *Municipal Corporations* (cities, towns and counties) eligible to provide unemployment relief as part of the state-wide relief program and subdivided for the purpose of the scope of their respective medical relief programs into the following population groups: (a) Cities with more than one hundred thousand population

(Jacksonville, Duval County; Miami, Dade County; Tampa, Hillsborough County). (b) Cities of twenty-five thousand to ninety-nine thousand nine hundred and ninety-nine population (St. Petersburg, Pinellas County; Pensacola, Escambia County; Orlando, Orange County; West Palm Beach, Palm Beach County). (c) Cities of ten thousand to twenty-four thousand nine hundred and ninety-nine (Lakeland, Polk County; Daytona Beach, Volusia County; Key West, Monroe County; St. Augustine, St. Johns County; Tallahassee, Leon County; Gainesville, Alachua County; Sanford, Seminole County). (d) Counties either rural or containing no towns with a population of more than ten thousand.

Item 2. *Professional Personnel.* Physicians, Dentists, Nurses and Registered Midwives.

a. On a unit (fee or maximum charge) basis.

b. On a salary basis.

c. Combination of a. and b.

Note: The participation of professional personnel under the categories listed above should be worked out by consultation between State and Local Relief Administrators and the State and Local Medical Advisory Committees. The adoption of any program should be governed by the availability of local clinic facilities and the conservation of relief funds through the development of a plan for providing good medical care at a minimum expenditure of public funds.

The traditional relationship existing between patient and professional attendant shall be recognized in the authorization of medical care under this program subject to the restrictions imposed by charter provisions, local statutory limitations, and the provisions of these Rules and Regulations.

In recognition of the principle of maintaining traditional relationships between patient and professional attendants where a preference is expressed by the patient, midwives, licensed to practice in the State of Florida, may be authorized to provide obstetrical care in the home to recipients of unemployment relief, subject to restrictions imposed by law and the provisions of these Rules and Regulations.

In order to provide adequate medical care it is recommended that local relief officers maintain on a district basis, approved lists or files of physicians and other licensed professional attendants who have agreed in writing to comply with these Rules and Regulations.

The Florida Emergency Relief Administration recommends that the local relief officers require signature on the following statement as a prerequisite to being placed on the authorized list of physicians or other professional attendants:

"The undersigned, a regularly licensed and/or registered.....(physician, dentist, nurse, other) hereby certifies that he (or she) is desirous of participating in the officially adopted program for providing medical care in the home to recipients of unemployment relief; that he (or she) has carefully read the Rules and Regulations adopted by the Florida Emergency Relief Administration to govern such medical care; and that he (or she) hereby agrees to conform to the provisions of said Rules and Regulations and to cooperate fully with the (City or County) Relief Administration and the Florida Emergency Relief Administration. My license is No., issued by the State of Florida, and my current registration is No....., Dated this....., day of 19

Address
(Street) (City)

(Signed)"

Section E.—Qualifications of Recipients of Medical Care.

Item 1. *Persons Eligible.* Medical care, under the provisions of these Rules and Regulations, shall be restricted to persons who are recipients of unemployment relief or who, upon investigation by the local relief officer, are found to be eligible for unemployment relief.

Item 2. *Other Restrictions.* Types of cases usually referred to physicians or other professional attendants who are paid on a salary basis from local and/or State funds, shall continue to be so referred: Provided, that adequacy of medical care can be maintained for these patients.

Item 3. *Persons Not Eligible: Procedure.* Patients who request medical care from the welfare office, but who do not qualify under the above requirements, should be referred to their family physicians or other professional attendants for free treatment, or for credit given by such family physicians or attendants, provided the physicians or attendants agree to give the necessary care.

CHAPTER II

Regulations Governing Procedure

In relief districts eligible to participate* in the statewide program of medical care provided in the home to recipients of unemployment relief, a uniform procedure for the authorization and provision of medical, dental, and bedside nursing care shall be established, which shall not be in conflict with the following regulations.

Regulation 1. Written Order Required. Item 1. *General.* All authorization for medical, dental and bedside nursing care shall be issued in writing by the proper authorizing officer of the local relief administration on the regular relief order blank, prior to giving such care; except that telephone authorization shall immediately be followed by such a written order; and provided that in the case of an emergency call the physician or other professional attendant shall request authorization from the local relief office within 48 hours after making such an emergency call.

Item 2. *Retroactive.* Any authorization for medical, dental or bedside nursing care issued more than 48 hours after the first call authorized shall be considered to be retroactive and payment for care rendered under such a retroactive authorization shall not be eligible for payment by the Administration.

Item 3. *Dental Care.* Authorization for dental care may, in cases where extensive treatment seems indicated, be restricted to authorization for one visit only, for the purpose of examination and estimate of necessary treatment. In such cases, additional written authorization, based upon the dentist's estimate, shall be required, prior to starting extensive treatment. Authorized dental care shall be limited to such work as is specifically indicated in the written order, and such order shall not be valid for more than thirty days from the date of issue.

Item 4. *Bedside Nursing Care.* Authorization for bedside nursing care, in welfare districts eligible to provide such care on a fee basis, shall as a rule be based on a recommendation by the attending physician, who shall certify to the need for bedside nursing service as an adjunct to the medical care.

Item 5. *Medicine, Medical Supplies, etc.* Authorizations for medicine, medical supplies and prosthetic devices shall also be issued in writing, prior to the provision of such materials and supplies, and, in general, such authorizations shall not be issued except upon written request of the physician authorized to attend the person for whose use they are desired.

Item 6. *Submission With Bill.* Written orders shall be submitted with the bill covering services performed under such orders, upon completion of the service.

Regulation 2. Acute Illness. Item 1. *Medical Care.* Authorizations for medical care for acute illness shall be limited to: not more than two weeks; not more than ten home and/or office visits; and an expenditure, as a basis for payment by the Administration, of not more than twenty dollars ($20).

Item 2. *Bedside Nursing Care.* Authorizations for bedside nursing care for acute illness, in districts eligible to provide such care on a fee basis, shall be limited to: not more than two weeks; not more than ten home visits; and an expenditure, as a basis for payment by the Administration, of not more than ten dollars ($10).

Item 3. *Renewal of Order.* Medical care in excess of this period or expenditure shall not be authorized until

*See Chapter I, Section D. Item 1, above.

after a reinvestigation of the case in the home by an accredited representative of the local relief administration.

Items 4 and 5. *Special Services.* Emergency; First Aid.

Item 6. *Additional Patients in Household.* When advice and/or care is given to other members of the same household by a physician or nurse in the course of an authorized home visit, an allowance for extra compensation for such additional care shall not be eligible for payment; nor shall an allowance for more than one member of the same household, seen in the course of an authorized office visit, be eligible for payment.

Regulation 3. Chronic Illness. Item 1. *Medical Care.* Medical care for prolonged illnesses shall, as a general rule, be provided through local agencies in accordance with the ruling made by the Florida Emergency Relief Administration.

Item 2. *Bedside Nursing Care.* Note: As a rule this service shall be provided through the state-wide bedside and public health nursing service, operated under the supervision of the Florida State Department of Health.

Regulation 4. Obstetrical Care. Item 1. *Scope.* Authorization for obstetrical service in the home shall include: prenatal care, delivery in the home, the postnatal care; and a requirement that, as far as possible, such obstetrical service shall conform both in frequency of visits and in quality of care, at least to the standards of maternity care approved by the Florida State Department of Health.

Item 2. *Not Emergency Service.* Maternity care should not be considered an emergency service to be authorized late in pregnancy. Local relief and health officials, public health nurses, social workers, family physicians and families on unemployment relief should cooperate to the end that continuous medical supervision should begin for every expectant mother as soon as pregnancy is suspected.

Item 3. *Minimum Standards.* a. Prenatal care. b. Delivery in the home shall include, in addition to obstetrical attendance for the mother, treatment for the infant as needed, including the administration of prophylaxis, to prevent blindness. c. Postnatal or postpartum care shall include care for both mother and infant as needed and a provision for a final gynecologic examination of the mother about six weeks after delivery or before she resumes usual activities.

Item 4. *Restrictions and Precautions.* Due caution shall be exercised that authorization for delivery in the home does not involve undue risk to a patient for whom hospital care may be imperative. The judgment of the attending physician shall be a decisive factor in issuing such an authorization. The physician authorized to attend the patient in the home shall be responsible for certifying to the local relief officer, that, in his professional judgment, delivery in the home will be safe.

Item 5. *Complications of Pregnancy.*

Item 6. *Miscarriage, etc.*

Item 7. *Prenatal Clinic.*

Item 8. *Emergency Hospitalization.*

Item 9. *Major Obstetrical Operations.*

Item 10. *Obstetrical Nursing.* (To be provided either through the state-wide bedside and public health service or by local arrangement.)

Item 11. *Care by Midwife.* Whenever an expectant mother eligible for home relief requests the attendance of a licensed midwife at her confinement, such service may be authorized, and arrangements should be made for adequate prenatal and postnatal care through existing community services. If there is doubt about the normal progress of pregnancy or delivery, the patient should be transferred immediately to a physician or to a hospital. Authorized obstetrical service provided by a licensed midwife may be eligible for payment by the Administration on the basis of not to exceed one-third to one-half of the fee paid to a physician for the same type of service.

Regulation 5. Special Services. Medical care not covered above shall be authorized only on an individual basis under the restrictions stated below and elsewhere in these regulations. Such special medical care shall not ordinarily be authorized by relief officials for conditions that do not cause acute suffering, interfere with earning capacity, endanger life, or threaten some permanent new handicap that is preventable when such medical care is sought.

Items 1-7. Special services may include first aid, x-ray treatments in physician's office, minor and major surgery and the reduction of fractures only on an emergency basis in patient's home, physicians' office or at the place of accident.

Item 8. *General Anesthesia, Surgical Assistance and Physiotherapy.* Physiotherapy shall not ordinarily be authorized for recipients of unemployment relief. If authorized, only on an individual and restricted basis.

Items 9 and 10. Laboratory and other special services on an individual basis, only, with maximum expenditures specified.

Regulation 6. Dental Care. Introduction. a. Emergency dental care in relief districts eligible to provide care under these Rules and Regulations, shall be restricted to these extractions, fillings, treatments and repairs which are necessary for the relief of pain and for the correction of conditions that interfere with earning capacity, endanger life, or threaten some permanent future disability that is preventable when dental care is sought.

b. Such dental care shall be authorized only as a supplement to existing community services or to services provided on a work relief or administrative basis, except in relief districts with no available dental services supported in whole or in part from local and/or State funds.

c. No dental program for school children shall be set up, under these regulations, which supplants a school dental service already supported by local and/or State funds.

Authorization and provision of dental care to recipients of unemployment relief shall be subject to the following requirements:

Item 1. *Extractions.*

Item 2. *Fillings.*

Item 3. *Treatment.*

Item 4. *Dental Prophylaxis.*

Item 5. *Dental X-ray Examinations.*

Item 6. *Special Dental Services.*

Item 7. *Repair of Dental Prosthetic Devices.* Note: Repair of prosthetic devices may be allowed only as a legitimate expenditure of emergency relief funds. Dentures should be provided, where necessary, along with other types of chronic care by the County Welfare Boards.

Item 8. *Maximum Expenditure.* Dental care shall not exceed twenty dollars for any single patient.

Regulation 7. Bedside Nursing Care. Introduction. a. Bedside nursing care to recipients of unemployment relief shall be provided, whenever possible, by registered nurses employed by the Administration, on a work relief basis, under the state-wide bedside nursing service supervised by the Florida State Department of Health throughout the State.

b. Bedside nursing care shall continue to be provided through existing community services, such as visiting nurses associations, public health nurses, etc., paid for in whole or in part from local and/or State funds, in accordance with local statutes and/or charter provisions.

Item 1. *Bedside Nursing, per Visit.*

Item 2. *Bedside Nursing, per Day.*

Item 3. *Home Helps, Practical Nursing.* In isolated communities where the services of a registered graduate nurse are not available and for the care of chronic illness not requiring expert attention or institutional care, "home helps" or practical nurse housekeepers may be authorized to provide necessary service, on a per diem basis, provided that the employment of such "home helps" is recommended by the physician in attendance on the patient.

Regulation 8. Medicine, Drugs, Sickroom Supplies and Prosthetic Devices. Such materials and supplies as are necessary to provide adequate medical care to

recipients of unemployment relief shall be authorized subject to the following restrictions imposed on each type, if payment from the Administration is contemplated for such authorized expenditures.

Item 1. *Medicine and Drugs.* a. Physicians providing authorized medical care to recipients of unemployment relief shall use a formulary which excludes expensive drugs where less expensive drugs can be used with the same therapeutic effect.

b. When expensive medication is considered essential by the attending physician it may be authorized after consultation with the local medical advisory committee: Provided that, to be eligible for consideration with a view to payment, the bill for such expensvie medication, shall be accompanied by the written approval of the local medical advisory committee.

c. Certain special remedies* which are in general use for the treatment of specific maladies and which have been accepted as approved in "New and Non-official Remedies" by the Council of the American Medical Association may be authorized with a view to payment, upon the prescription of the attending physician without further consultation.

d. With the exceptions noted above, prescriptions for necessary drugs and medicine shall be restricted to the latest edition of the National Formulary and/or the United States Pharmacopeia; and proprietary or patent medicines, patent infant foods, except for the simple dried milks such as Klim and Dryco, and prescriptions containing proprietary remedies, shall not be eligible for payment by the Administration. Substitutions shall be made, from the National Formulary or the United States Pharmacopeia, for certain proprietary remedies, for example: phenobarbital should be substituted for luminal; hexamethylenamin for urotropin; silver nucleinate for argyrol; etc.

Item 2. *Sickroom Supplies.* Authorization for medical and sickroom supplies shall be restricted to the simplest *emergency* needs of the patient consistent with good medical care. Such authorization shall be issued only on the basis of a physician's prescription for an individual patient and shall be confined to such necessary items as gauze, adhesive tape, cotton, ear syringe, eye cup, ice bag, clinical thermometer, hot water bottle (not electric pad), and hypodermic syringe and needles (for diabetics).

Item 3. *Prosthetic Devices and Surgical Appliances.* a. Authorizations for necessary prosthetic devices shall be issued to meet emergency needs only, and shall *not* include, with a view to payment, such expensive devices as artificial limbs, vulcanite dentures, etc. Such devices may be authorized by the county welfare board but such authorization shall not be eligible for payment by the Administration.

Note: Surgical and prosthetic devices shall not be provided for persons eligible to receive such appliances under the Cripple Children's Act (indigent persons under seventeen years of age).

b. Optical supplies, including eye glasses, shall be authorized, with a view to payment from relief funds, only upon the written prescription of a licensed physician who, in his specialty as an oculist or ophthalmologist, is permitted to use drugs in examining eyes. The payment for such an examination and prescription shall be restricted by the provisions of Item 4 of Regulation 9, below.

Expenditures for eye glasses shall be eligible for payment only when they are provided under the following conditions: 1. When glasses are necessary in order to enable a recipient of unemployment relief to secure employment; 2. When, in the opinion of the examining physician-oculist eyesight is endangered because of lack of glasses; 3. When the patient cannot attend to usual household tasks, or a child cannot make proper progress in school without glasses; and 4. When, according to the attending physician-oculist or ophthalmologist, the patient has a disease or defect of the eye which requires glasses for its cure or correction.

Regulation 9. Schedule of Approved Charges. Introduction. a. It is realized by the Administration that with the funds available, it is impossible to compensate fully the physician, dentist or nurse for his or her professional services. The following schedule of charges, therefore, should not be considered as complete compensation for services rendered but rather as a maximum basis for payment, with due consideration for the conservation of relief funds to the mutual benefit of the patient, the professional attendant and the taxpayer.

The following schedule of approved charges was prepared following a conference in Ocala, Florida, on December 9, 1934, between authorized representatives of the Florida Medical Association and the Florida Emergency Relief Administration.

b. The charges listed are hereby established by the Administration as the maximum eligible for payment under these Rules and Regulations.

Section A. *Medical Care.* (Personal Services.) The services of a physician, authorized with a view to payment by the Administration, shall be subject to the restrictions imposed by these Rules and Regulations, and expenditures for such services shall be eligible for payment at not to exceed the following schedule of charges:

Item 1. *Home Visit.* Authorized home visits, subject to the restrictions imposed by Section D, and Regulations 1, 2 and 3, above, shall be payable at a rate not to exceed $2.00

At night, (after 9 P. M.) at not to exceed..... 3.00

Mileage beyond the city limits at six cents per mile both ways, until such time as the Florida State Legislature makes adequate appropriation for relief, after which time it shall he ten cents per mile.

Item 2. *Office Visit.* Authorized office visits, subject to the restrictions stated for Item 1, above, shall be payable at a rate not to exceed..... $1.00

Item 3. *Obstetrical Care.* Authorized obstetrical care in the home including necessary prenatal care, delivery in the home and postnatal care, subject to the general restrictions and requirements imposed by these Rules and Regulations and specific requirements of Regulation 4, above, shall be eligible for payment.

a. For the services of a physician, on the basis of a flat rate for delivery in the home, shall not exceed $15.00; prenatal care at a rate not to exceed $1.00 per visit, with a maximum for such prenatal care at a rate not to exceed..... 5.00; postnatal and postpartum care (visits on the third, tenth and forty-second days postpartum are recommended) at the regular rate for home and/or office visits.

b. For the services of a midwife, subject to the requirements of Item 2, c, Section D and Item 11, of Regulation 4, above, on the basis of a rate not to exceed..... 5.00

c. For the services of a physician, authorized to attend a confinement in the home of a patient in the second stage of labor, decides that hospitalization is imperative for the safety of the mother and child, at a rate not to exceed.... 10.00; only in cases where the need and circumstances for such hospitalization are set forth in detail in the physician's bill.

SPECIAL SERVICES

Section B. Item 4. *The Usual Services of a Specialist.* Authorized services of a specialist shall be subject, for the purposes of payment, to the general restrictions of these Rules and Regulations and the specific requirements of Item 1 of Regulation 5, and shall be eligible for payment at a rate not to exceed..... $2.00

Such services include: refraction; eye, ear, nose, throat and skin treatment; intramuscular and intravenous therapy; etc.

*Such as insulin, liver extract, digifolin and similar compounds of digitalis, ephedrin and its compounds, argyrol, petrolagar and other mixtures containing only mineral oil and agar-agar.

Items 5-13 include x-ray minor surgery, reduction of fractures, general anesthesia and physiotherapy and other special services on an individual basis not to exceed fifty per cent of the established local fee schedule.

SECTION C. *Dental Care.* (Personal Services.) Extractions, fillings, treatment dental prophylaxis, x-rays, special dental services and maximum expenditure.

SECTION D. *Bedside Nursing Care.* (Per visit, per day and practical nursing.)

SECTION E. *Materials and Supplies.* Introduction. a. The scope of materials and supplies which may be provided to recipients of unemployment relief shall include necessary medicine, drugs, sickroom supplies and prosthetic devices, subject to the restrictions imposed by these Rules and Regulations.

b. Local relief administrators are urged to make trade agreements or request bids for the provision of these materials and supplies, in order that available relief funds may be conserved.

Item 1. *Medicines and Drugs.* a. Physicians providing authorized medical care to recipients of home relief shall use a formulary which excludes expensive drugs where less expensive drugs can be used with the same therapeutic effect. Medicine and drugs ordered in writing by a physician, shall be authorized subject to the general restrictions of these Rules and Regulations and the specific requirements of Item 1 of Regulation 8, above, and shall be eligible for payment at charges not to exceed the following: These rates assume that the usual compounded prescriptions will include 12-24 capsules, pills or powders; 3-4 ounce mixtures; or 12-ounce tonics.)

b. Compounded prescriptions containing no rare or costly drugs..... .50-.75

c. Uncompounded prescriptions for ordinary drugs 30-.50

d. Uncompounded prescriptions for the more expensive drugs 50-.75

e. Compounded or uncompounded prescriptions for special and more costly medicines and preparations, such as insulin, at prices not to exceed: 20 per cent more than the wholesale price listed in the current "Druggists' Circular" plus a service charge not in excess of (in cases where the drugs are compounded)..... .25

f. Simple drugs furnished by a physician in the course of a home or office visit shall not ordinarily be eligible for payment except as part of the service provided under an authorized visit. In certain instances where a physician, in the more isolated communities, dispenses large quantities or more expensive drugs, a claim may be submitted for payment at a rate not to exceed..... .50
Provided, that the claim lists the name and quantity of each drug, and complies with the restrictions imposed by Item 1 of Regulation 8, above.

Item 2. *Sickroom Supplies.* Necessary sickroom supplies shall be authorized as a rule only on the order of a physician, and expenditures, for such materials, subject to the restrictions imposed by Item 2 of Regulation 8, above, shall be eligible for payment either:

a. On the basis of the price secured by competitive bids, or

b. In any case at a price not to exceed..... 20% more than the standard current wholesale price for such materials.

c. Provided that, the name of the physician issuing the order for necessary sickroom supplies shall be made a part of the claim for payment.

Item 3. *Prosthetic Devices and Surgical Appliances.*

a. Orthopedic and surgical appliances.

b. Repair of dentures.

c. Optical Supplies. Subject to the general restrictions imposed by these Rules and Regulations and the specific requirements of Item 3, f, of Regulation 8, above, authorized expenditures for eye glasses shall be eligible for payment preferably on the basis of prices obtained by competitive bids, at charges not to exceed the following:

1. Average lenses and frame, of standard quality, per pair 2.25 to 3.50

2. Toric lenses and frame, of standard quality, per pair 2.75 to 3.75

3. Bifocal lenses and frame, of standard quality, per pair..... 4.00 to 5.50

The above charges do not include the charge for the prescription for the glasses, which is subject to the restrictions imposed by Item 4 of this Regulation. In addition to the specifications for the lenses, the prescription shall also give measurements necessary to insure that frames will fit: namely, pupilary distance, size of nose piece, and temple length.

Regulation 10. BILLS. The following procedure is hereby established for the submission of bills for services and materials authorized for the purpose of providing more adequate medical care to recipients of unemployment relief.

Item 1. *General Requirements.* a. Physicians, dentists, nurses, druggists and others who are providing authorized medical care, to recipients of unemployment relief, under the requirements of these Rules and Regulations, shall submit to the local relief official, monthly (within 10 days after the last day of the calendar month in which such medical care was provided), an itemized bill for each patient.

b. Each bill shall be chronologically arranged and shall contain full details as required in Items 2 to 4, below, to permit proper audit.

Item 2. *Specific Requirements.* a. Physicians, dentists, nurses and other professional personnel providing authorized personal services to recipients of unemployment relief shall submit, in their bills, the following details: date and number of written order; name, age, and address of patient (also name of the head of the household receiving home relief, unless he or she is the patient); diagnosis, or specific indication of the nature of the illness (acute or chronic); whether treatment was given in the patient's home or in the office of the physician or dentist, with full details, if unusual services are given; a chronological list of the dates on which services were rendered; and the status of the case at the end of the month—"cured, needs further treatment, hospitalized (give date and name of hospital), dead (give date of death), etc."

b. Druggists or pharmacists.

c. Medical supplies.

Item 3. *Bill Form.* Bills shall, as a rule, be submitted on Florida Emergency Relief Administration form adapted to present the details required in this regulation. Bills for medical care (including personal services of physician, dentist, nurse, etc., and materials and supplies) shall be accompanied by the original written order, except for cases in which medical service under an authorization has not terminated during the calendar month covered by the bill, in which cases the bill shall show, in addition to the details required above, the date and serial number of the outstanding order.

Item 4. *Retroactive Bills.* Bills submitted for services or materials and supplies provided on the basis of retroactive authorization as defined in Item 2 of Regulation 1, above, shall not be eligible for payment by the Administration.

Regulation 11. PROFESSIONAL AUDIT AND ARBITRATION. The Administration is desirous of maintaining professional standards in the provision of medical care to recipients of unemployment relief, and solicits the cooperation of the organized profession in establishing arrangements for providing medical and other professional service may be conducted under professional supervisions of Section C of Chapter I of these Rules and Regulations, audit and arbitration of bills for professional service may be conducted under professional supervision with regard to: reasonableness of any individual bill for authorized service; failure to maintain professional standards; proposed changes in policy and procedure; and principles to be followed in the allocation of cases to physicians.

Regulation 12. MONTHLY REPORT. The local relief administration shall submit at the end of each calendar month a monthly report of total medical, dental, nursing

*Section b, Special Services.

services and drugs and medical supplies, authorized and submitted for payment for the preceding month. This report should contain a summary of relevant data for each physician, dentist, nurse and druggist, including: the number of different patients for whom care was authorized, number of home visits; number of office visits; number of confinements; number of special services; and total charge on all claims included in bills.

Regulation 13. Authorization of Change in Scope of Local Program. The local program of medical care adopted under these Rules and Regulations shall be subject to the restrictions imposed by Items 1 and 2, Section D, above. No change in the scope of local services, provided under existing statutes from non-relief funds shall be made with a view of securing payment from the State Administration for such services, without prior written approval by the Administration. A request for approval in change of scope of the local program of medical care shall be accompanied by detailed monthly records of the services in question for a period of not that these services are not adequate to give needed care less than the two preceding years, as well as evidence to recipients of unemployment relief.

CORRESPONDENCE

The State Hospital

January 2, 1935.

To the Editor:

Upon invitation from the Governor, it was my pleasure to meet with the Cabinet at 10:00 o'clock, January 2, for the purpose of discussing conditions at the hospital in Chattahoochee.

Considerable discussion followed the reading of my statement and we finally arrived at the following conclusion: That the Board of Commissioners of State Institutions heartily agreed that the recommendations presented in my statement were right with the exception of the first recommendation—*i. e.*, that of a medical superintendent for the hospital. However, as I have said before, the Governor has made the appointment and, in all probability, the appointment will stand until another Governor and his Cabinet are elected. The remainder of the recommendations will doubtless be carried out if, as, and when the Legislature appropriates sufficient money for that purpose.

In all, the meeting was very satisfactory and I feel that some good was accomplished by it. I have been promised a certified copy of the minutes of the meeting which will be forwarded for publication in an early issue of the Journal. The copy of these minutes will include a complete statement of my recommendations.

(Signed) Homer Pearson, M.D.,
President.

STATE NEWS ITEMS

The new postoffice box address of the Florida Medical Association and of the Journal is 1018, Jacksonville, Florida.

* * *

On October 27 the members of the Cancer Control Committee enjoyed the hospitality of Dr. and Mrs. J. C. Dickinson at dinner in their home in Tampa.

After the dinner, a meeting of the Committee was held. New films received from the American Society for the Control of Cancer, designed for exhibition before lay audiences, were shown and studied.

Arrangements were made for the campaign during the winter season. Communications from the Woman's Auxiliary of the State Association were received. The Woman's Auxiliary is planning a campaign on cancer education which will probably be conducted in cooperation with various women's clubs throughout the state.

Mrs. Illig, Chairman of the Public Health Committee of the National Federation of Women's Clubs, is much interested in cancer educational programs and is endeavoring to stimulate the various State Federations to hold symposia on this subject.

The Committee made plans for giving all assistance in its power to these programs. It stands ready to supply trained speakers who will be provided with films, lantern slides, and other material necessary to put over these symposia.

Various other topics pertaining to the situation were discussed during the session.

* * *

The Southeastern Surgical Congress held its first state clinical session at Cuthbert, Georgia, on November 22. The meeting was held at the hospital of Dr. J. C. Patterson who kindly put all the facilities of his institution at the disposal of the Congress.

Dr. Gerry R. Holden of Jacksonville, Florida, President of the Congress, was present and gave a clinical demonstration of the late results of the treatment of benign uterine hemorrhage with radium element.

This meeting was extremely well attended. In addition to members of the Congress, a number of invited guests from western Georgia and northwest Florida were present.

It is the plan of the Congress to develop similar

clinical sessions in the various states which make up its membership.

During March, 1935, the Spring session of the Southeastern Surgical Congress will be held in Jacksonville. Past meetings of this organization have been well attended. Over seven hundred and fifty physicians were registered at its meeting in Nashville last March.

As much interest is being manifested in the coming Jacksonville meeting, it will undoubtedly be very well attended.

* * *

Dr. and Mrs. Thomas S. Anderson of Live Oak celebrated their golden wedding anniversary on December 17. A host of friends wish them many more happy and healthful years together.

* * *

Dr. Herbert E. White of St. Augustine and Dr. Robert B. McIver of Jacksonville attended the meeting of the Southern Surgical Association recently held at Sea Island, Georgia. They were the guests of Dr. Dan C. Elkin of Atlanta.

FREDERICK GREENE BARFIELD

Dr. Frederick G. Barfield died at his home in Jacksonville, December 25, following an illness of a few weeks' duration. He was born March 13 at Cuthbert, Georgia, and was 61 years of age.

Dr. Barfield was graduated from the medical school at the University of Virginia in 1897. He came to Jacksonville in 1916 and made his home there since that time.

During the World War, Dr. Barfield distinguished himself as division surgeon of the Eighty-Second Division. He entered the army as a captain in the Medical Corps and rose to the rank of lieutenant colonel.

Dr. Barfield is survived by his widow, Mrs. Helen Denham Barfield, a son, William Denham Barfield and a nephew, Frederick Dunn of Cuthbert.

L. R. WEEKS

Dr. L. R. Weeks of Trenton died on the morning of December 26, following a lengthy illness. Dr. Weeks is survived by his widow and three children, L. R. Weeks, Jr., Howell Tucker Weeks and Madaline Weeks.

Dr. Weeks was for many years a valued member of the Florida Medical Association.

Dr. J. G. Lyerly announces the opening of offices in suite 405, Medical Arts Building, Jacksonville. His practice will be limited to neurological surgery.

* * *

Dr. Homer Pearson, President of the Association, has announced the appointment of Dr. Louis Orr of Orlando as Councilor for the Seventeenth District. Dr. Orr will complete the unexpired term of Dr. Gaston Edwards, deceased.

* * *

The many friends of Dr. J. L. Chalker of Ocala will regret to learn of the death of his wife, Ellen Smith Chalker, on December 18.

* * *

Dr. F. Clifton Moor of Tallahassee, Councilor for the Second District, has been appointed Chairman of the Council by President Homer Pearson. Dr. Moor will fill the vacancy created by the death of Dr. Gaston Edwards.

* * *

Dr. J. W. Vaughn, formerly associated with Dr. Herman Watson of Lakeland, announces the opening of his offices on the fifth floor of the Marble Arcade Building, Lakeland.

* * *

Dr. John S. McEwan of Orlando has returned from Sea Island, Georgia, where he attended the meeting of the Southern Surgical Association.

* * *

Dr. W. M. Rowlett, Secretary of the State Board of Medical Examiners, reports that of the sixty applicants who took the November 12th examination there were twenty-one failures. Fourteen applicants were turned down on the ground of educational qualifications. The highest grade, 91.3%, was made by Dr. Nathan L. Marcus of the Tampa Municipal Hospital, a graduate of the University of Louisville. Second to the highest grade, 88.5%, was made by Dr. Frank G. Slaughter, Jacksonville, a graduate from Johns Hopkins. Six of the 21 failures graduated from Illinois colleges. Vanderbilt had 1 failure, University of Illinois 2, Howard 1, Cincinnati Eclectic 1, Rush 2, Meharry 1, Barnes 1, Arkansas 1, Louisville 1, University of Havana 3, University of Oklahoma 1, Chicago University 1, Johns Hopkins 1, Loyola 1, Atlanta Physicians and Surgeons 1, Ohio University 1, and the

University of Vermont 1. The following successful applicants were duly licensed:

Andrews, Charles R., Jr., 926 Myrtle St., N. E., Atlanta, Ga.; Emory University.

Askew, P. H., Jr., Jackson Memorial Hospital, Miami; Georgia University.

Austin George C., Jackson Memorial Hospital, Miami; Virginia University.

Boorom, Hartley E., 606 Lake Dot Circle, Orlando; Albany University.

Bowen, Carroll T., Canaseraga, New York; Buffalo University.

Bradford, W. H., Bay Pines, Florida; Cincinnati University.

Brunson, Francis A., Sumter, S. C.; South Carolina University.

Carter, C. L., Tampa Municipal Hospital, Tampa; Georgia University.

Childress, H. M.; Jackson Memorial Hospital, Miami; Louisville University.

Garcia, Luis del Sol, Tampa Municipal Hospital, Tampa; Georgetown University.

Dodd, William E., Beach Haven, N. J., Pennsylvania University.

Ermshar, H. F., 1503 E. No. Ave., Baltimore, Md.; Evangelists Med.

Evans, G. H., 356 N. W. 9th St., Miami; Meharry Med.

Farringer, R. H., 221 No. East 5th St., Miami; Hahnemann Medical of Philadelphia.

Freeman, A. R., Albany, Georgia; Emory University.

Gilbert, J. T., Jr., Nashville General Hospital, Nashville, Tenn.; Vanderbilt University.

Harris, Robert D., Marion, N. C.; Georgia University.

Harriss, R. R., Bellevue Hospital, New York City; Johns Hopkins.

King, F. G., 20 Ft. Marion Circle, St. Augustine; Emory University.

Klein, L. A., St. Luke's Hospital, Jacksonville; Cincinnati University.

Lytle, Carl S., Bartow, Jefferson Medical.

Marcus, Nathan L., Tampa Municipal Hospital, Tampa; Louisville University.

McMurray, J. W., Bartow; Tulane University.

Megna, J. A., Municipal Hospital, Tampa; Rush University.

Meitin, Ruth, Tampa Municipal Hospital, Tampa; Rush University.

Murphey, D. R., Jr., University Hospital, University, Virginia; Vanderbilt University.

Nelson, Orville N., U. S. Veterans Hospital, St. Petersburg; Minnesota University.

Pearce, N. O., Minneapolis, Minnesota; Minnesota University.

Perdue, J. R., Miami Beach, Fla., Virginia University.

Scarborough, C. A., Jackson Memorial Hospital, Miami; Virginia University.

Slaughter, Frank G., Riverside Hospital, Jacksonville; Johns Hopkins Medical.

Smiseth, Selmer P., Suttons Bay, Mich.; University of Michigan.

Sory, C. H., Memorial Hospital, Fort Lauderdale; Tennessee University.

Strumpf, Irving J., 3713 Richmond St., Jacksonville; Bellevue Medical.

Stuteville, Ethel, Laconia, N. H.; Indiana University.

Tribble, Charles E., DeLand; Yale University.

Watkins, J. O., Municipal Hospital, Tampa; Virginia University.

Watters, P. H., Strong Memorial Hospital, Rochester, N. Y.; Rochester University.

Zimmerman, Maurice, 235 Cypress Ave., New York City; New York Homeopathic Medical.

* * *

The Southeastern Surgical Congress, through its secretary, Dr. B. T. Beasley, announces the sixth annual assembly of the Congress which will be held in Jacksonville, Florida, March 11, 12 and 13, 1935. The Congress has met previously in Atlanta, Birmingham and Nashville.

The states composing the Congress are Alabama, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee and Virginia. A record attendance is anticipated at the Jacksonville meeting. Since March is the most desirable month to visit the Land of Flowers, many surgeons will no doubt combine business and pleasure and attend during this season of the year.

Some of the most distinguished surgeons in the country representing the different surgical specialties have been invited to appear on the program. A partial list of those who have already accepted places is as follows: Doctors Walter C.

Alvarez, Perry Bromberg, Hugh Cabot, Willis C. Campbell, George W. Crile, John F. Erdmann, Paul Flothow, Ralph Greene, Arthur Hertzler, C. Jeff Miller, Alton Ochsner, J. C. Patterson, J. Knox Simpson, J. W. Snyder and W. A. Weldon. More than twenty others will be listed when the program is completed. Look for the completed program which will be mailed about February 15, 1935.

For information address Dr. B. T. Beasley, Secretary-treasurer, 1019 Doctors Building, Atlanta, Georgia.

COMPONENT COUNTY SOCIETIES

DADE COUNTY MEDICAL SOCIETY

DADE COUNTY MEDICAL SOCIETY FINISHED THE YEAR 1934 IN FINE FASHION. IT HEADS THE GROUP OF 100% PAID SOCIETIES. WITH A PAID MEMBERSHIP OF 194 MEMBERS IN 1934, THIS SOCIETY IS THE LARGEST IN THE STATE. INFORMATION HAS JUST BEEN RECEIVED THAT SEVERAL NEW MEMBERS HAVE VERY RECENTLY AFFILIATED THEMSELVES WITH THE SOCIETY, BRINGING THE MEMBERSHIP OVER 200.

The following scientific papers were presented at the meeting of the Dade County Medical Society, held at the Huntington Club Rooms, Miami, January 4, at 8:30 p. m.:

"The Common Cold," D. H. Grimes.

"Anginal Syndrome and Coronary Thrombosis," E. Sterling Nichol.

The following committees of the Dade County Medical Society have been appointed by the Society's president, Dr. Wm. W. McKibben, to serve for 1935:

Executive Committee — William McKibben, president; M. Jay Flipse, vice-president; H. A. Barge, treasurer; R. T. Spicer, secretary; E. B. Maxwell, chairman Board of Censors; R. N. Burch, Board of Censors; Duncan Owens, Board of Censors; Elmo French, editor of Bulletin.

Medical Economics—M. Jay Flipse, chairman; Thomas Hutson, Homer L. Pearson, Milton Coplan, R. O. Lyell, Frank R. Morrow, J. Raymond Graves.

Public Health and Legislation—C. E. Tumlin, chairman; E. S. Nichol, E. C. Thomas, John Turner, George MacDonell, R. M. Harris, Joe Stewart.

Publicity and Public Relations—W. A. Haggard, chairman; Roy Holmes, Gerard Raap, John D. Milton, Jack Cleveland, L. A. Baker, A. H. Weiland.

Program—Gerard Raap, chairman; Frazier Payton, E. Clay Shaw, Stewart Jeffrey, Wiley M. Sams, M. H. Tallman, Juel M. Baker, Taylor Lewis.

Auditing — Carl Dunaway, chairman; Max Dobrin, W. L. Fitzgerald, Rothwell Lefholz, J. D. Stuart, A. W. Wood.

Mosquito Control—Harrison A. Walker, chairman; W. McKibben, G. N. MacDonell, C. T. Roche, J. A. Smith, F. E. Kitchens, C. H. Withers, Roy Holmes, Homer Pearson.

DUVAL COUNTY MEDICAL SOCIETY

At the January second meeting of the Duval County Medical Society, the following scientific program was presented:

"Neurology from the Viewpoint of the General Practitioner," Ralph Greene.

"Mechanical Aids in Neurosurgical Diagnosis," J. G. Lyerly.

HILLSBORO COUNTY MEDICAL SOCIETY

At a special meeting of the Hillsboro County Medical Society, held December 26, the following resolution was passed with reference to the appointment of Dr. William J. Lancaster to the post of chief medical officer for the Atlantic Coast Line Railway:

Whereas, Doctor William J. Lancaster has the honor of having been elevated to the position of Chief Surgeon for the Atlantic Coast Line Railway System, necessitating the change of residence from Tampa to his official headquarters, Wilmington, North Carolina; and,

Whereas, this appointment is a signal honor and the first to be bestowed on one of our members, distinguishing the Hillsboro County Medical Society, and,

Whereas, Doctor Lancaster has been an exceptionally active and energetic member in the civic welfare of this community and in the advancement of medicine in Tampa and the state generally, as well as one of our city's outstanding citizens, and,

Whereas, Doctor Lancaster is generally known to his patients as very subserviant and kind in his relationship, and generous and fair to the profession, establishing a distinguished career of service to organized medicine,

Be it, therefore, resolved, that the Hillsboro County Medical Society regrets the loss of Doctor Lancaster's membership and his presence, but are gratified to congratulate and wish him God speed in his future welfare.

R. R. Duke,
E. S. Gilmer,
E. W. Bitzer,
H. Mason Smith,
Committee.

Passed by a unanimous vote at a special meeting of the Hillsborough County Medical Society, December 26, 1934.

G. C. Bottari, M.D.,
President.

Attest: John S. Helms, Jr., M.D.,
Secretary.

LAKE COUNTY MEDICAL SOCIETY

The following resolutions were passed at the January meeting of the Lake County Medical Society:

Whereas, Almighty God, the Giver of live and Father of All Creation, in His infinite wisdom, has called from the labors of this mortal life to his reward with the Heavenly Host, our esteemed friend and fellow worker, Doctor Gaston H. Edwards; and

Whereas, through his sterling character, his outstanding ability and his upright adherence to ethical practices, Doctor Gaston H. Edwards was an inspiration to those of the Medical Profession who were privileged to know him, and

Whereas, he served with honor and credit his nation, his state and his community and gave generously of his services and means to the relief of the sick and afflicted and to the upbuilding and development of his community, and

Whereas, his advice and council has been of valuable assistance to the staff of the Lake County Medical Center and to the practicing physicians of Lake County, and the loss of his friendship and association will be keenly felt, now

Therefore be it resolved, that the membership of the Lake County Medical Society and the staff of the Lake County Medical Center extends thanks to the Giver of Life for the friendship and association of this exemplary life which has so recently taken on immortality behind the shadows which curtain the Sunlight of Eternal Morning.

And be it further resolved, that we express to the bereaved family of our friend and fellow, Gaston H. Edwards, our deep and profound sympathy and pray that solace may come to those who grieve through the knowledge of a life spent in service to and accomplishment for Humanity, and

Be it further resolved, that a copy of this resolution be spread upon the minutes of this meeting and a copy be furnished to the press.

Approved and adopted, in meeting assembled, on the Second day of January, Nineteen Hundred Thirty-five.

Lake County Medical Society,
by Resolutions Committee.
M. M. Hannum, M.D., Chairman.
S. C. Colley, M.D.,
W. L. Ashton, M.D.

ORANGE COUNTY MEDICAL SOCIETY

The Orange County Medical Society met in regular session December 19. Dr. Carl D. Hoffmann presented a very interesting paper on "Sterility." This was followed by the annual election of officers which resulted as follows:

President—Dr. T. M. Rivers.
Vice-President—Dr. W. E. Sinclair.
Treasurer—Dr. Horace A. Day.
Secretary and Reporter—Dr. J. A. Pines.

Dr. H. M. Beardall was elected to the five-year term as a member of the board of trustees to replace Dr. C. D. Christ, the retiring member.

Dr. Horace A. Day was re-elected for two years as delegate to the state convention, and Dr. W. H. Spires was elected his alternate. The holdover delegates whose terms expire one year from date are Drs. C. D. Christ and G. H. Edwards. Their alternates are Drs. Hewitt Johnston and C. J. Collins.

The president, Dr. Rivers, appointed the following committees to serve for 1935:

Program Committee:
President—Dr. T. M. Rivers.
Vice-President—Dr. W. E. Sinclair.
Secretary—Dr. J. A. Pines.

Committee on Public Health and Legislation:
Dr. Spencer A. Folsom.
Dr. Horace A. Day.

Publicity Committee:
Dr. J. R. Chappell.
Dr. C. J. Collins.
Dr. H. M. Beardall.

Banquet Committee:
Dr. Meredith Mallory.
Dr. Hewitt Johnston.
Dr. Louis Orr.

Committee on Public Policy:
Dr. T. A. Neal.
Dr. D. T. McEwan.
Dr. G. S. Osincup.

Radio Program Committee:
Dr. W. H. Spiers.
Dr. J. H. Buff.
Dr. L. C. Ingram.

The secretary and treasurer then read their annual reports which were accepted and filed.

On February 7 the Pre-convention Meeting of the Florida Medical Association will meet with this society. A general invitation is extended through the Journal to the physicians of Florida to attend this meeting and greet Dr. Walter L. Bierring, President of A. M. A., who will be Honor Guest and deliver an address at the evening session. Following this address the Orange County Medical Society will entertain the visiting physicians at a buffet supper.

It was voted to invite the Florida Tuberculosis and Health Association to hold their annual meeting in Orlando at a date to be announced in March or April. Arrangements are being made to have a nationally known speaker on tuberculosis at this meeting.

The president appointed committees to visit and extend Christmas greetings to two members who were ill, Drs. W. C. Persons and P. M. Lewis.

(Annual Report of the Secretary)

The Orange County Medical Society was organized in 1908 with nine charter members, three of whom are still with us: Drs. W. C. Persons, J. S. McEwan, and C. D. Christ. In all we have had one hundred twenty-five members. Some have been taken by the hand of the grim reaper, many have moved to other fields, and a few have been dropped for various reasons.

At the beginning of 1934 we had a membership of forty-nine. During the year one member was granted a demit to join elsewhere, one was dropped, and one, Dr. C. J. Marshall, was taken from us by death. Eight new members were added to our society; namely, Drs. Walter Weed, Robert G. Wood, L. L. Andrews, L. M. Sutter, R. B. Taylor, Clarence W. Lynn, Read Calvert, and Claude Anderson. We are now entitled to three seats in the house of delegates at the state convention. At present we have fifty-four active members and two honorary members.

Twelve regular meetings and two special meetings were held during the year, with a total attendance of four hundred twenty-six. Six of our members, Drs. Edwards, Gardner, McBride, Pines, Spires, and Rivers, have a perfect attendance record.

Nine papers were read by members of our own society and three by invited guests.

An active interest is manifest by practically every member of our Society and a spirit of unity and cooperation exists for which we feel justly proud.

J. R. Chappell, President;
J. A. Pines, Secretary.

VOLUSIA COUNTY MEDICAL SOCIETY

THE VOLUSIA COUNTY MEDICAL SOCIETY ATTAINED ITS GOAL. 100% OF MEMBERSHIP DUES WERE PAID BY THIS SOCIETY FOR 1934. LAST YEAR'S OFFICERS OF THIS SOCIETY ARE TO BE CONGRATULATED.

At the annual meeting of the Volusia County Medical Society, the following officers were elected for 1935:

President—G. A. Davis, DeLand.
Vice-President—H. W. Henry, New Smyrna.
Sec'y-Treas.—Hugh West, DeLand.

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WOMAN'S AUXILIARY

TO THE

FLORIDA MEDICAL ASSOCIATION, INC.

State Editor

MRS. S. M. COPELAND

1356 Willowbranch Ave.,

Jacksonville, Florida

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MRS. S. M. COPELAND, Press and Publicity *Jacksonville*

GREETINGS TO ALL AUXILIARY WOMEN

As leader for the coming fiscal year of the Woman's Auxiliary to the Florida Medical Association, I greet you with very best wishes—hoping we may have a most pleasant and profitable year.

It is with a great deal of pleasure that I am offering my services and that of my official family, in helping you to outline your program for the year, if you do not have it already planned.

The National Organization gives us rather wide scope in the planning of our programs and we have the opportunity of doing the work we most enjoy, as well as that best suited to each individual community. However there are some things required of us. The first is that our County Organizations be made uniform throughout the State, having the same fiscal year and time for election of officers. This is vital and the whole administrative system of State and National Auxiliary is based upon this simple fundamental principle. Our State Auxiliary Board voted last year to ask for this uniformity. To comply with this request it will be necessary for some counties to change their fiscal year and it should not be made later than the first week in April. If all county dues be paid to the State Treasurer on the last day of the same fiscal year, she will have time to balance her books and make her reports in a systematic manner, for the State Convention the first week in May. If we will but realize that the County Auxiliary is the basic unit and the performance and ultimate achievement of every plan proposed by our State and National Auxiliary depends primarily upon the County Auxiliary, we will then feel how necessary we are and appreciate our great responsibilities.



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The National Auxiliary has also asked each county organization to devote one meeting to Auxiliary history—County, State, and National. Study material can be procured and I will get it for you if you will write me.

We should make use of the Auxiliary Study Envelopes, they cost us nothing, and new ones are being printed from year to year. Mrs. John F. Wilson, Program or Health Chairman, Lakeland, will send at your request, a list of those available and will order your selection if you wish.

Have you a Handbook? As you know this is our official textbook, from which we may study our duties and responsibilities. It is compiled by women high in Auxiliary work and is of real value to every Auxiliary member. I have ordered a supply of the new edition and they are 40c each. May I send you one?

You have received the charge from Dr. Pearson for this year's work. I must remind you of your responsibility in helping the State Auxiliary officers in their endeavor to carry it through. There is nothing unreasonable required of us but it will mean cooperation to the fullest degree. Read the Charge at several meetings so all members may know what we are to do and prepare to help us.

As members of woman's clubs and other clubs we are often called upon to serve on health committees. Let us always be found ready and may we realize that it is not only a privilege to serve but it is our duty to do so. As doctors' wives we have an honor that cannot belong to other women. And by living side by side with men who are spending their lives for suffering humanity we are bound to have a different viewpoint. I contend we are best fitted to guide lay club women in planning health programs and in a quiet non-aggressive way we can side-track the erroneous and misleading propaganda that is so constantly kept before the public.

Am sure we will all agree that "The Necessity of Health Cards for Household Servants", is of vital interest to us here in Florida, but the seriousness of it is not realized. I am trying to get some "3 minute" talks suitable to be given by some good lay speaker in each community, before all clubs, especially the P. T. A. Will send each of you one when they come.

Dr. Holden and his Cancer Committee will soon have their Cancer Prevention Program ready and we will be hearing from Mrs. J. R. Wells, Public Relations Chairman. Mrs. Wells wishes

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—Proc. Soc. Exp. Biol. and Med., 1934, **32**, 241-245.

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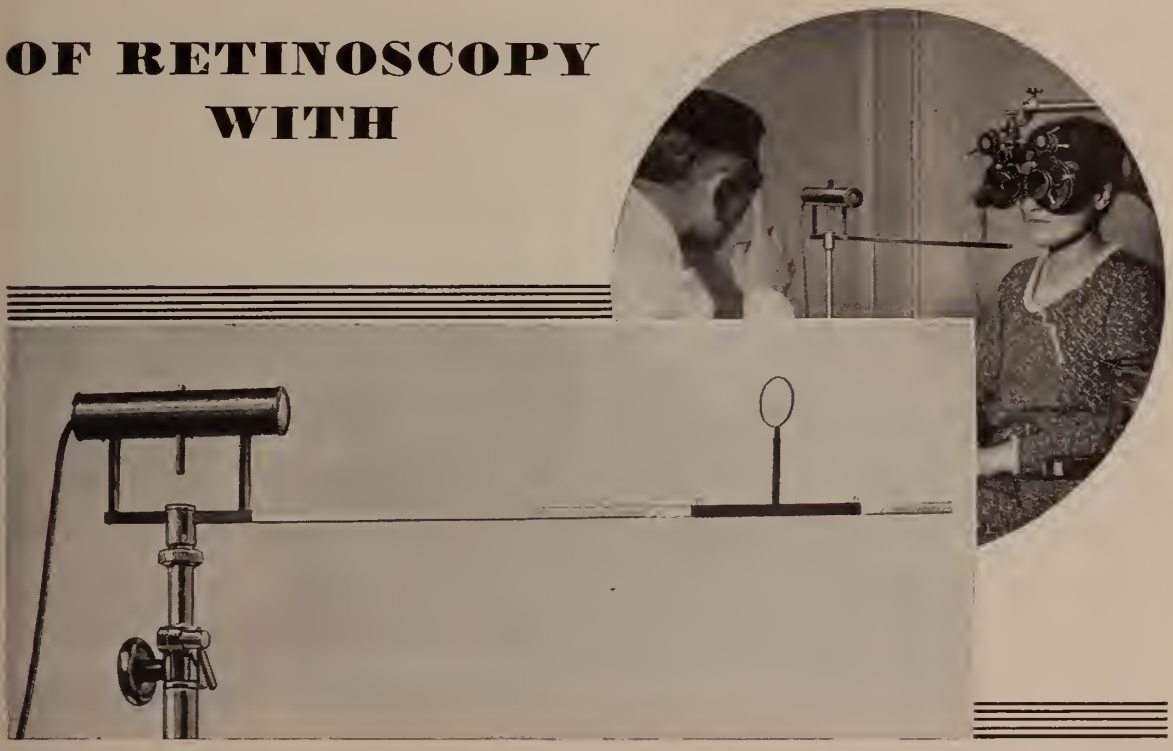
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to assist us in arranging for as many meetings in each county as possible, for the public presentation of cancer prevention literature and pictures. I understand Dr. Holden has new pictures and that he is very enthusiastic about his program. I would advise that each County Auxiliary take a vote on this subject at your very next meeting and write to Mrs. Wells, Daytona Beach, Box 9. Write her if you do want the meetings, how many and where, but write her even if you do *not* want them. Of course you understand the program must be presented at the convenience of the State Committee and we can help very materially by letting them know at once whether or not we are interested.

All of us have read of the plans of the Tuberculosis Association to build Sanitoria throughout the State to care for our T. B. patients. We do not know *how* nor *when* but we do believe it *will* be *done* sometime. The best way we can help the Association, at the present time, is to cooperate in the sale of Christmas Seals to help furnish the funds that are so necessary to carry on the campaign.

I am afraid that here in Florida we do not yet realize the value of Hygeia. This National Health Magazine is published by the American Medical Association for the purpose of giving out *authentic* information on various phases of health. The Medical knowledge conveyed in Hygeia is so easy to understand and is given in such a colorful and interesting manner that all classes may enjoy reading it. If it were possible to place this magazine in all doctors' and dentists' offices, schools and libraries, so it would be within reach of all laity, not only would much wicked propaganda be defeated, but the value of ethical medical profession understood. Won't you put your shoulder to the wheel and help us to, at least, sell our quota this year? And wouldn't it be wonderful if we could double it.

Right here is where we need more County Auxiliaries and let us go about getting them. Only eight organizations out of sixty-seven counties is too poor a showing and we must change it. Let us try to interest our neighboring counties in organizing.

Do you read the Bulletin or does your husband carry it to his office and keep it there Well, there is so much of interest and help on its pages that every woman trying to do Auxiliary work should read it. If you will write to the A. M. A., and send fifty cents, you may have the Bulletin a year for your very own.

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Also read our page in the State Medical Journal. It is an inspiration to know of the activities of other societies and how many are helping our Press and Publicity Chairman, Mrs. S. M. Copeland, with her page in the Journal. Do you realize that as she sits up there at her desk in Jacksonville, she would have nothing to write of county affairs except the "goings on" of her own Duval Auxiliary, unless we tell her? Please write to her when you have a specially good meeting and when you do anything for the advancement of our work. We would be glad to hear of a unique way of making money for subscriptions to Hygeia.

And now, dear co-workers, as the time is short we must be up and doing. Let us make our plans carefully and wisely and then work consistently toward their achievement. I assure you of my great appreciation of the part that you are playing in this work, for without your help and cooperation we could not hope to succeed. Cooperation is the key word of success.

With best wishes for a happy and successful year, I am,

Most sincerely,

(Mrs. E. R.) Edith McMurray,
President.

Polk County Auxiliary

The meeting of the Polk County Medical Society and the Woman's Auxiliary was in the form of a barbecue, held in the nurses' home of the Morrell Memorial Hospital.

After the dinner hour, the doctors' wives assembled at the hospital, where bridge tables were assembled, but instead of cards being on the tables, stacks of gauze greeted everyone and during the next hour, hospital sponges were made. When the total number was estimated on the attractive Christmas tallies, Miss Mary Jane Thornhill, a graduate nurse who instructed the ladies as to how the sponges were made, was high scorer, and Mrs. J. W. Vaughn was second high. Each was presented a piece of Fostoria glassware. About 2,000 sponges were made.

After this, the business meeting was called to order by the president, Mrs. G. C. Overstreet. A letter was read from the state president, Mrs. E. R. McMurray, of Bartow. The most important things stressed in this letter were:

(1) That if the Auxiliary had not already outlined its work for the year, there were several things to be considered; each County Auxiliary

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should have the same fiscal year, to end not later than the first week in April.

(2) Devote one meeting of the year to Auxiliary history.

(3) That the doctors' wives are best fitted to guide other club women as to health matters, and a very important thing to be done is to have every family examine their maids; in other words, have laboratory work done on them before accepting them for work.

(4) Mrs. Wells of Daytona Beach would like to have cancer meetings in the counties.

(5) That the best way to assist in the building of a tuberculosis sanatorium in Polk county is to help in the sale of the seals.

(6) That we should realize more the importance of Hygeia, and try to sell our quota; this is where we need more Auxiliaries.

(7) Read special page in the State Medical Journal.

. Jars of jellies and jams were brought by the women for the emergency shelf at the hospital.

Two new members were welcomed. They are Mrs. T. H. Roberts and Mrs. L. B. Nicholson, both of Lakeland. Mrs. J. W. Vaughn was made publicity chairman.

* * *

Pinellas County Auxiliary

Mayor Francis B. Keesling, vice-president and general counsel of the West Coast Life Insurance Company and H. K. Lindsley, president of the Farmers' and Bankers' Life Insurance Company of Wichita Kansas, were guest speakers at the monthly meeting and luncheon of the Woman's Auxiliary to the Pinellas County Medical Society Tuesday noon, Dec. 4th, at the Yacht club. Both spoke on the close association between the medical profession and life insurance.

A musical program was given by Edwin A. Leonhard, pianist, who is making his home here.

During a short business meeting, reports of committees were presented and a donation voted to The Times Empty Stocking fund.

Mrs. K. Hummeland of Maywood, Ill., a member of the Cook County Auxiliary, and Mrs. H. C. Stepan were guests at the luncheon.

* * *

The Auxiliary to the Pinellas County Medical Society held its first fall meeting Tuesday, Oct. 23, 1934, when it enjoyed a luncheon and social session at the Pipin' Hot tea room at Gulfport.

Mrs. Wyman W. Harden, newly elected president, presided at a brief business meeting when

About seventeen members were present.

plans for the new year were discussed.



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COUNTY SOCIETY	SECRETARY	MEETINGS				Dues Paid.
		Date	Time	Place	Luncheon?	
Alachua	Harry M. Merchant, M.D., Gainesville.	2nd Tuesday	12:00 Noon	White House Gainesville	Yes.	
Bay	Allen H. Miller, M.D., Millville.					
Brevard	L. K. Hicks, M.D., Melbourne.	2nd Tuesday		Varies	Yes.	
Broward	O. C. Brown, M.D., Ft. Lauderdale.	Last Wednesday.	8:00 P.M.	Elks' Hall Ft. Lauderdale	No.	
Columbia	T. H. Bates, M.D., Lake City.	1st Monday	7:30 P.M.	Blanche Hotel Lake City		100%
Dade	Robert T. Spicer, M.D., Miami.	1st Friday	8:30 P.M.	Club Room Huntington Bldg. Miami	Occasionally.	
DeSoto-Hardee-Highlands	L. W. Martin, M.D., Sebring.	2nd Tuesday	8:00 P.M.	Varies	Yes.	
Duval	Charles B. Mabry, M.D., Jacksonville.	1st Tuesday	8:15 P.M.	Mayflower Hotel Jacksonville	No.	
Escambia	J. M. Hoffman, M.D., Pensacola.	2nd Tuesday	8:00 P.M.	Board of Health Building Pensacola	No.	
Hillsboro	John S. Helms, Jr., M.D., Tampa.	1st Tuesday	8:00 P.M.	Tampa Municipal Hospital Tampa	No.	
Jackson	Lewis Pierce, M.D., Marianna.	2nd Tuesday	7:30 P.M.	Hotel Chipola, Marianna	Yes.	
Lake	W. L. Ashton, M.D., Umatilla.	1st Thursday	12:30 P.M.	Eustis	Yes.	28%
Lee	Robley D. Newton, M.D., Ft. Myers.	3rd Friday	7:30 P.M.	Lee Memorial Hospital Ft. Myers	No.	
Leon-Gadsden-Liberty-Wakulla-Jefferson	O. G. Kendrick, M.D., Tallahassee.	Quarterly	8:00 P.M.	Varies	Yes.	
Madison	Geo. O. Davis, M.D., Madison.					
Manatee	W. D. Sugg, M.D., Bradenton.	3rd Tuesday	7:00 P.M.	Whitfield Country Club Bradenton	Yes.	
Marion	Richard C. Cumming, M.D., Ocala.	3rd Thursday	12:30 P.M.	Marion Hotel Ocala	Yes.	
Monroe	W. R. Warren, M.D., Key West.	1st Sunday	9:00 P.M.	Varies	Yes.	
Orange	John A. Pines, M.D., Orlando.	3rd Wednesday	8:30 P.M.	Varies	No.	
Palm Beach	R. Henry Baldwin, M.D., W. Palm Beach.	4th Monday	8:00 P.M.	Good Samaritan Hospital W. Palm Beach	No.	
Pasco-Hernando-Citrus	Geo. R. Creekmore, M.D., Brooksville.	2nd Thursday	7:00 P.M.	Varies	Yes.	
Pinellas	O. O. Feaster, M.D., St. Petersburg	1st Friday	8:00 P.M.	Assembly Room, 5th floor, P. & L. Bldg. St. Petersburg	No.	50%
Polk	J. R. Boulware, Jr., M.D., Lakeland.	2nd Wednesday in Feb., Apr., June, Aug., Oct., Dec.	1:00 P.M.	Lakeland	Yes.	
Putnam	E. W. Warren, M.D., Palatka.	2nd Thursday	7:00 P.M.	James Hotel, Palatka	Yes.	
St. Johns	Reddin Britt, M.D., St. Augustine.	3rd Tuesday	8:30 P.M.	Varies	Yes.	7%
St. Lucie-Okeechobee-Indian River-Martin	J. D. Parker, M.D., Stuart.	3rd Thursday	8:00 P.M.	Varies	Yes.	
Sarasota	J. E. Harris, M.D., Sarasota.	2nd Tuesday	8:30 P.M.	Varies	Occasionally.	
Seminole	J. T. Denton, M.D., Sanford.	2nd Monday	7:00 P.M.	City Hospital Sanford	Yes.	
Sumter	W. E. Mitchell, M.D., Coleman.	2nd Tuesday		Varies	No.	
Taylor	C. A. O'Quinn, M.D., Perry.	Last Friday	8:00 P.M.	Dixie-Taylor Hotel Perry	Yes.	
Volusia	Hugh West, M. D., DeLand	2nd Tuesday	7:30 P.M.	Varies	Yes.	
Walton-Okaloosa	A. G. Williams, M.D., Lakewood.	3rd Thursday	8:00 P.M.	Varies	Occasionally.	

NOTE—Secretaries: Please submit information to complete the above schedule.



NEW YORK ACADEMY OF
MEDICINE

SIXTY-SECOND ANNUAL MEETING, OCALA, MAY 13, 14, 15, 1935

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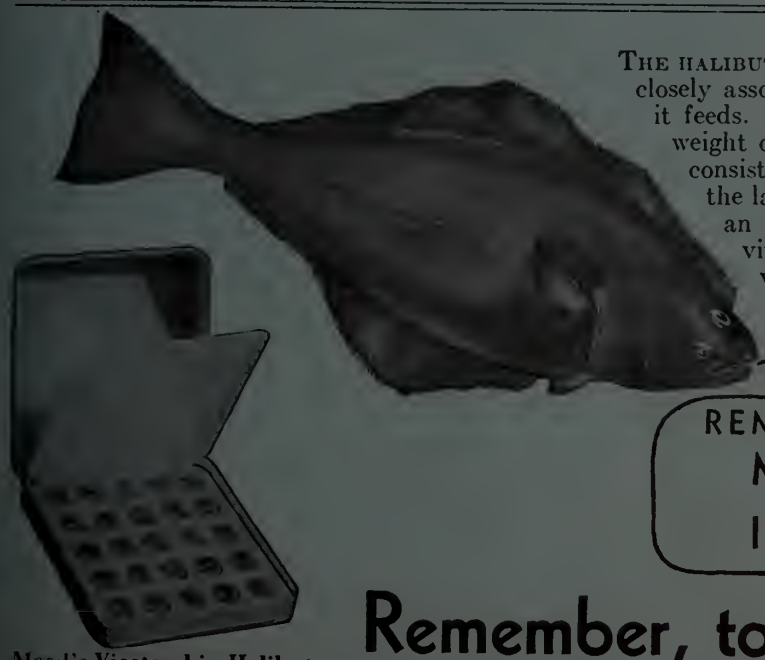
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NEXT SESSIONS Florida Medical Association, Ocala, May 13, 14, 15, 1935.
American Medical Association, Atlantic City, June 10-14, 1935.
Southern Medical Association, St. Louis, November 19-22, 1935

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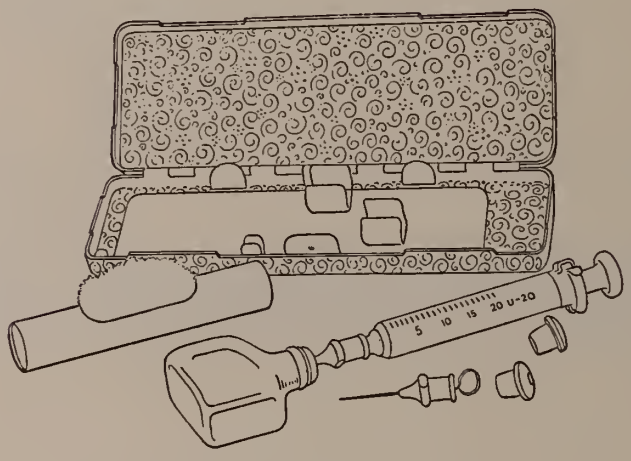


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CLINICAL NATURE OF MALIGNANCIES AND THE PRINCIPLES OF TREATMENT*

J. S. Turberville, M.D.,
Century.

The subject is rather hackneyed, but nevertheless intriguing. Cancer is mentioned in the Papyrus Ebers (1500 B. C.) and in the oldest remnants of the literature of Persia and India (Ewing.[1]) Roger and Roland from the School of Salerno about 1170 A. D. knew about cancer (Garrison[2]) Johanes Müller wrote about tumors in 1838 (Garrison[3]).

Any organ or structure of the body may have a neoplasm of any of its contained elements. The skin may have a growth from the connective tissue elements, or epithelial elements and these in turn will vary with the different kinds of connective tissue, or different kinds of epithelia; for example, lipomata, fibromata, sweat gland cancer, sebaceous gland cancer, or simple squamous cell cancer. This holds for all the organs and structures.

Certain types of individuals and certain races are prone to have certain types of tumors. The fair skin types have cancer of the skin oftener than the dark types. In my own experience cancer of the skin in negroes is exceedingly rare, and cancer of the breast less frequent than in the whites. On the other hand, carcinoma of the cervix uteri is quite as common as that of the whites. Fibroid tumors of the uterus are more common in negroes than in the whites, and come at an earlier age, about five years earlier, according to my own observation. People exposed to weather, and those to certain irritants, have cancer of the skin oftener than those not so exposed. Men have cancer of the stomach more often than women, but have cancer of the breast or prostate much less often than women do of cancer of breast or uterus. Sarcoma is a disease of younger people and cancer of senescence.

*Read before the Sixty-first Annual Meeting of the Florida Medical Association, Jacksonville, April 30, May 1 and 2, 1934.

The inclusion or cell rest theory of the origin of cancer has been the most popular. There is no doubt about teratomata having such origin, but it is very questionable in regard to many tumors. Should we accept this notion exclusively, the question of why we do not all have neoplasia would still be unanswered. The many theories of the causes of neoplasia rest on one or more postulates. There are two generally accepted factors in the production of malignancies, viz.: trauma or chronic irritation, and some alteration of metabolism either local or general. Ewing[4] in his discussion on etiology of cancer, and experimental research mentions the various theories, and is inclined more to the belief that the cell rest theory and cell automaticity, explain the cause more than the other theories. He takes a decided stand against the infection theory.

There are certain outstanding clinical features about cancer that impress even the casual observer, and these are that it is a disease of senescence and that it attacks the uterus most often about and beyond the time of the menopause in women (45 years and up), and the prostate about the time and beyond that period of life when the gonads have begun to wane decidedly in their function (65 years and up). The gonads must have a powerful influence on epithelial metabolism, particularly of the genital tract.

Each cell in the body has its general metabolism and in addition its special metabolism necessary in the performance of its function. Therefore the tendency to cancer may be general or local. In the former irritation or trauma may cause a neoplasm anywhere, but in the latter it would not arise except in the organ of altered metabolism. This is in agreement with clinical observation. Notice, if you please, that some people's skin will have one cancer after another, at different sites and of independent origin. I once saw a man with cancer of the face and cancer of the stomach. In the latter case I would say there was general alteration of metabolism, and in the former local alteration. When we are sufficiently informed, I imagine we will find that every organ will have or elaborate some hormone for its gov-

ernment. or for that of others, and any alteration will make our cells susceptible to lawless growth from slight trauma. Distant and local infections, anatomic and physiologic decline, nutritional disorders. etc., may so disturb the finely balanced hormonal systems that very slight trauma might turn the growth of the cell from its special function to one of purely vegetative existence. This notion is like the others, because it must rest on postulates. Really all the theories of the causes of cancer are explanations by hypotheses, and are therefore worthless.

The clinical nature of cancer is that of growth. local at first, but soon spreads by infiltration and permeation of the surrounding structures. Later when particles become detached by any means they may be transported by the lymph or blood stream to local or distant parts. and there begin life anew, and the cells are of the same type as that of the parent growth. Carcinomata metastasize oftenest by lymph stream or by permeation ; perhaps the latter is much more frequent than is generally believed. Observation of syphilis will show very often that a chancre on one side of the penis will cause enlargement of the lymphnodes on that side of the inguinal region, the corresponding axilla, epitrochlear and cervical nodes, and practically no change of the other side. This means that there has been an invasion of the walls of the lymph vessels on this side from the point of origin to the wide extension just mentioned. If this is true of syphilis, it is not too much to expect of cancer.

Neoplasms from certain regions have a predilection for lodgement and growth in certain structures. Carcinomata anywhere in the area drained by the portal vein usually metastasize to the liver ; the prostate to the bones of the pelvis, vertebrae and femora ; the breast to lungs and bones. and strange to say often to the femora ; the thyroid often to the bones. The lungs by reason of their anatomical situation and structure are most often the seat of metastases from sarcoma because these malignant emboli are most often blood stream borne. Why some emboli pass the lung filter and reach the bones at a distance is not known. This may be due to smallness of the particles.

I herewith submit a short statistical review of some of the writer's own work.

For the last ten years, I have treated nearly all cases of cervical carcinoma with radium, having found only two that I thought were suitable for both radiation and hysterectomy. Practically all of the cases have involved the cervix and surrounding tissue so extensively that operation would have been foolish. At first radium was applied rather timidly and the results of course were poor, but lately the teachings of the French school have been followed, viz : small doses over a period of several days applied to the cervix, within the cervix, and within the corpus, the vaginal vault being pushed as high as possible by packing gauze in the vagina. A male catheter is fastened in the bladder and this to a tube under the bed. The patients are kept under observation for many years. Subsequent treatments are given according to indications. One's judgment must be very discriminating in order not to do damage with radium, as at times, it is almost impossible to differentiate between malignancy and radium necrosis.

In the breast cases the whole breast axilla and infraclavicular space is laid off in rectangles, and each rectangle radiated as much as the skin will bear, with rather heavy screening. At the end of this time the breast, pectoral muscles, the subclavicular, axillary, and subscapula fat and lymph nodes are removed. Nerves are disregarded where there is any doubt of the wisdom of leaving them. The vessels are cleaned and the small vessels are ligated close to the main trunk. I do not make a practice of going above the clavicle, as I think when these nodes are involved, operation is useless.

In cancer of the skin—the warty and the mole-like growths are radiated and removed by the electric knife ; the scaly and the ulcerating type usually by radiation, but sometimes by excision.

The cancers of the stomach have all been inoperable. Gastroenterostomy was performed to prevent starvation in a few cases. Cancers of the colon have all been inoperable except one. This was excised ; the patient died of infection of the wound and embolism. Cancers of the rectum have been inoperable, except for colostomy.

Malignancies of the bone of the extremities, have been treated by amputation and excision of the neighboring lymph node bearing areas, and radiation. Only one cancer of the mouth except the lips has been treated. This was incurable, and radium was applied as a palliative.

There was one sarcoma of the skull, treated palliatively by excision of the ulcerating mass with electric knife and radium application.

On the whole, except for cancers of the skin. results of treatment have been, very unsatisfac-

Cancer of the Cervix, 42 (33 White, 9 Colored)
Cancer of the Cervix involving Contiguous structures, 25; Cervix alone, 17

Pathological Type
- Papillary Adenocarcinoma, 1
- Not made, 25
- Epidermoid, 1
- Squamous Cell, 10
- Squamous Cell and Adenocarcinoma, 1
- Not mentioned, 4

Treatment
- Radium, 38
- Panhysterectomy, 1
- Panhysterectomy and Radium, 3—1 living
- Two of Panhysterectomy cases had only involvement of the Cervix, the other had involvement of the Vaginal Vault—bilateral pus tubes and fibroid tumor

Results
- Involving Contiguous structures
 - 2 living 6 months
 - 14 lost sight of
 - 7 dead
 - 1 living 17 months, has Vesico Vaginal Fistula
 - 1 living 32 months, when last heard from had a Recto Vaginal Fistula
- Cervix alone
 - 2 living 4 months
 - 2 living 4 years
 - 1 living 1 month
 - 2 living 5½ years
 - 1 living 4½ years
 - 2 living 3½ years
 - 1 living 3 years
 - 2 dead—lived 3 years
 - 1 dead—lived 2 years
 - 1 dead—lived 9 years—died of metastases of the lungs
 - 2 lost sight of

Vagina 2
- Operated elsewhere and I excised the inguinal lymph nodes. Result—patient died, but lived several months.
- Pathological Type. Epidermoid. Treatment—radium. Result—living 18 months.

Ovary 2.....
- Pathological Type—no examination made. Treatment—removal. Result—lost sight of.
- Pathological Type—not made. Treatment—laparotomy. Result—lost sight of.

Corpus Uteri 4....
- Pathological Type—Deciduoma Malignum. Treatment—hysterectomy. Result—died.
- Pathological Type—Sarcoma of fibroids. Treatment—supravaginal hysterectomy. Result—lost sight of. Reason for no radiation and the Cervix not being removed was Sarcoma not being discovered until after operation.
- Pathological Type—Adenocarcinoma. Treatment—radium. Result—living 6 months.
- Pathological Type—Adenocarcinoma. Treatment—radium till strong enough for operation. Panhysterectomy on 23 of April, 1934.

Cervix and Corpus Uteri 2
- Pathological Type—Squamous cell. Treatment—radium. Result—living 3 years.
- Pathological Type—not determined on account of previous radiation. Treatment—radium. Result—living 18 months.

Corpus Uteri with fibroids 2.. ..
- Pathological Type—Adenocarcinoma. Treatment—radium. Result—living 3 years.
- Pathological Type—Adenocarcinoma. Treatment—radium, later panhysterectomy when patient has recovered from anemia sufficiently. Result—living 5 months.

Cervix Corpus and Vagina... Pathological Type—not mentioned. Treatment—radium and panhysterectomy. Result—died after 18 months.

CERVIX, CORPUS AND OVARIES—Total cases, 55. Average age, 46.

Prostate 9..... (6 White, 3 Colored)
- Pathological Type—not made. Treatment—none. Result—lost sight of.
- Pathological Type—not made. Treatment—none. Result—lost sight of.
- Pathological Type—not mentioned. Treatment—removal of prostate. Result—died in 38 hours from Cerebral Embolism.
- Pathological Type—not mentioned. Treatment—removal of prostate and applied radium. Result—died 6 months later of Vertebral Metastasis.
- Pathological Type—not mentioned. Treatment—removal of prostate and applied radium. Result—lived 3 years.
- Pathological Type—not mentioned. Treatment—removal of prostate and applied radium. Result—died several months later from suppression of urine.
- Pathological Type—not mentioned. Treatment—removal of prostate. Result—died several months later.
- Pathological Type—Adenocarcinoma. Treatment—removal of prostate. Result—died after 3 weeks.
- Pathological Type—no examination made. Treatment—removal of prostate. Result—died of Vertebral Metastasis.

Bladder 2.
- Pathological Type—examination not made. Treatment—radium. Result—died a few weeks later.
- Pathological Type—examination not made. Treatment—radium. Result—died a few weeks later.

Gastrointestinal... (Not including the Mouth)

Stomach. .
- Pathological Type—not made. Treatment—drew off peritoneal fluid. Result—died after leaving hospital.
- Pathological Type—not made. Treatment—gastroenterostomy. Result—died in hospital.
- Pathological Type—not made. Treatment—gastroenterostomy. Result—lived many months.
- Pathological Type—not made. Treatment—gastroenterostomy. Result—died in hospital.
- Pathological Type—not made. Treatment—gastroenterostomy and gall bladder drained. Result—died, lived many months.
- Pathological Type—not made. Treatment—exploratory. Result—died after a few weeks.

Colon... .
- General Peritoneum. Pathological Type—not made. Treatment—exploratory laparotomy. Result—died.
- Sigmoid and Liver. Pathological Type—Adenocarcinoma. Treatment exploratory laparotomy. Result—died after going home.
- Sigmoid and Liver. Pathological Type—Adenocarcinoma. Treatment—excision. Result—died of wound infection and embolism.
- Sigmoid. Pathological Type—not made. Treatment—colostomy. Result—died.
- Colon and Jejunum. Pathological Type—not made. Treatment—exploration. Result—died in a few weeks.
- Transverse Colon and general Peritoneal cavity. Pathological Type—Adenocarcinoma. Treatment—cecostomy. Result—died after going home.

Rectum....
- Upper. Pathological Type—not made. Treatment—colostomy. Result—died in a few weeks.
- Lower, and Anus involving skin and muscle. Pathological Type—Adenocarcinoma. Treatment—colostomy and radium. Result—died after 2 years.
- Lower. Pathological Type—not made. Treatment—radium. Result—lost sight of.
- Rectum and Colon. Pathological Type—not made. Treatment—colostomy. Result—lost sight of.

Mesentery and general peritoneal cavity. Pathological Type—Fibrosarcoma. Treatment—exploration. Result—died after going home.
Pancreas. Pathological Type—examination not made. Treatment—drained common duct. Result—died 12 months later.
Iliac Fossa. Pathological Type—Sarcoma. Treatment—exploration. Result—died after going home.
Larynx. Pathological Type—Squamous cell. Treatment—tracheotomy and gastrostomy-radium. Result—died after 1 year.
Abdominal Wall. Pathological Type—Fascial large cell sarcoma. Treatment—excised. Result—living 29 months. Had two previous excisions.
General Abdominal—mostly pelvic. Pathological Type—not made. Treatment—exploratory. Result—died after several months.
Lymphatic nodes—general. Pathological Type—Chorioma-testis. Treatment—biopsy and palliative excision. Result—died after a few weeks.

Cancer of the Breast (13 White, 2 Colored)
- Axillary involvements, 12.
- No Axillary involvements, 3.

Pathological Type...
- Scirrhus, 1.
- Duct Carcinoma, 2.
- Alveolar Carcinoma, 1.
- Carcinoma simplex, 1.
- Papillary Adenocarcinoma, 1.
- Carcinoma simplex and Adenocarcinoma of ducts, 1.
- Adenocarcinoma, 3.

Treatment
- Radium and dissection of axilla but not muscles, 1.
- Radical operation without radium, 4.
- Radium with radical operation, 6.
- Excision and Radiation, 1.
- Radium application, 1.
- Radium and simple amputation, 2.

Results
- Living 6 months, 1.
- Died—lived 2 years, 1.
- Died—length of time not known, 1
- Died—lived 2 years, 1.
- Died—lived 3 years, 1.
- Living 7½ years—simple amputation, no axillary involvement, 1.
- Died of spinal metastases—lived 8 years, 1.
- Died—lived 2½ years, 1.
- Died—lived 3 years, 1.
- Living 2 years but doomed, 1.
- Living 18 months, no axillary involvement, 1.
- Living 12 months, but has returned in axilla and metastasis to the spine, 1.
- Living 2½ years, 1.
- Living 2 years, 1.
- Living 15 months, no axillary involvement, 1.

I haven't treated so many skin cases; most having been treated by my associate.

Skin..... (30 White, 1 Colored)
- Temple. Pathological Type—not mentioned. Treatment—radium—returned, excision and radium. Result—living 5½ years.
- Back. Pathological Type—Adenoid Epithelioma. Treatment—excision with electric knife and radium. Result—living 3½ years.
- Temple. Pathological Type—Epidermoid. Treatment—excision with electric knife and radium. Result—lost sight of.
- Mastoid. Pathological Type—Epidermoid. Treatment—with electric knife and radium. Result—living 3½ years.
- Auricle. Pathological Type—Basal cell Epithelioma. Treatment—radium and excision with electric knife. Result—living 1½ years.
- Parotid region involving the gland. Pathological Type—Squamous cell. Treatment—excision with electric knife and radium. Result—living 2½ years.
- Dorsum of the hand. Pathological Type—Papillary Squamous cell Epithelioma. Treatment—excision with electric knife and radium. Result—living, 1 year later, had cancer of nose.
- Beneath the lower jaw. Pathological Type—Basal cell Epithelioma. Treatment—excision with electric knife and radium. Result—living 28 months.
- Lower lip. Pathological Type—not made. Treatment—radium. Result—lip cured but returned in the jaw, died after about 20 months.
- Mastoid and Auricle. Pathological Type—Basal cell Epithelioma. Treatment—radium. Result—living 18 months. No return but new cancers elsewhere.
- Hand and Axilla. Pathological Type—Epithelioma, solid type. Treatment—excision of glands, radium to hand. Result—died after 6 months.
- Abdominal wall and Axillary Lymph nodes. Pathological Type—Melanoma. Treatment—excision and dissection of Axillary nodes with electric knife and radium. Result—died 2 months later with general metastasis.
- Parotid region involving the gland. Pathological Type—Squamous cell. Treatment—radium and electro-coagulation. Result—living 8 months.
- Hand with Axillary involvement. Pathological Type—not made. Treatment—amputation, excision of lymph nodes with scalpel. Result—lived 12 years, died Pneumonia.
- Hand and Face. Pathological Type—not made. Treatment—radium and amputation of the arm. Result—died later from those of the face.
- Leg involving the bone. Pathological Type—Squamous cell. Treatment—amputation. Result—lost sight of.
- Hand. Pathological Type—not made. Treatment—amputation. Result—lost sight of.
- Hand. Pathological Type—not made. Treatment—amputation. Result—lost sight of.
- Eye, including Conjunctiva and Sclera, Nose and Ear. Pathological Type—not made. Treatment—enucleation of eye with electric knife, radium—removal of ear later. Result—died, not from recurrence but new lesions.
- Forehead, Chin and Lip involving the bone. Pathological Type—not made. Treatment—excision with electric knife and radium. Result—living 4½ years.
- Cheek. Pathological Type—not made. Treatment—radium and excision with electric knife. Result—living 4½ years.
- Foot. Pathological Type—not mentioned. Treatment—radium, later excision with electric knife. Result—living 5½ years.
- Temple. Pathological Type—not mentioned. Treatment—excision with electric knife. Result—living 5 years.
- Upper lip. Pathological Type—not made. Treatment—radium. Result—living 3 years.
- Cheek. Pathological Type—Basal cell Epithelioma. Treatment—excision and radium. Result—living 2 years.
- Angle of the Jaw. Pathological Type—Basal cell Epithelioma. Treatment—excision and radium. Results—living 2 years.
- Side of Face. Pathological Type—not made. Treatment—radium. Result—living 8 months.
- Lower lip. Pathological Type—not mentioned. Treatment—excision. Result—living 13½ years but paste was applied, after operation by a fakir.
- Side of Neck. Pathological Type—not made. Treatment—radium. Result—dead.
- Penis. Pathological Type—Epidermoid. Treatment—amputation and block dissection of inguinal regions. Result—living 12 months.
- Temple. Pathological Type—Basal cell. Treatment—excision with electric knife. Result—living 4 months.

Bone 2 ...
- Pathological Type—Sarcoma of bone marrow. Treatment—amputation of leg. Result—living 4½ years.
- Pathological Type—not made. Treatment—amputation of thigh. Result—lost sight of.

Jaw Pathological Type—Squamous cell, Mucosa and bone. Treatment—radium. Result—died after leaving hospital.

Origin Not Known. Epitrochlear gland. Pathological Type—Sarcoma. Treatment—excision and radium. Result—died, lived 2 years.

tory. However, for every case of cancer that lives beyond three years, except in rare instances, the doctor so treating must be credited with prolonging the patient's life.

The principles of treatment should rest on the general behavior of these growths, and are first, removal of any general or local cause, that may disturb cell metabolism; second—removal of or prevention of trauma or irritation; third—removal by excision, cautery or radiation of any suspicious growth, bearing in mind the infiltrating and metastasizing habits of cancer; fourth—when positive remove not only the growth, but the lymphatic vessels and nodes that are most likely first infected; fifth—when possible radiation should be prior to surgical removal; sixth—in some situations radiation is distinctly the best treatment, for example, most skin cancers, (melanomata excepted), and the cervix uteri.

A reasonable clinical diagnosis of malignancies can be made in most cases if certain details are observed in history taking and meticulous care taken in making the examination. The race, age, sex, social position, number of children, occupation, length of time of symptoms, progress of the lesion, organ affected, the patient's own idea of its cause, presence or absence of trauma or irritation, and lesions of similar nature in other regions of the body should be considered. The examination should begin with a general physical examination. The shape, color, consistency, presence of ulceration, fixity to surrounding structures should be observed, and if ulcerated, is there evidence of healing at any point? Condition of neighboring lymph nodes? Evidence of lung, liver or bone metastases? If these data are obtained and properly assembled, the conclusion is very apt to be correct; at least it will indicate the desirability or not of further investigation.

Hypothetical Specimen Case:

White woman. Married, age 45 years, 5 para, youngest 5 years.

Menstrual history, normal till six months ago, then the flow became more profuse and lasted a day or two longer. At the same time she noticed a leukorrheal discharge in the intermenstrual period. Three months ago she noticed some blood after sexual intercourse. A month ago she began to spot even when she did not have intercourse, and the leukorrhea was now profuse.

There is slight anemia and nothing to account for it in her history, except the complaint mentioned. External genitals show some relaxation of perineum; speculum examination shows an enlarged cervix with moderate bilateral laceration; some of cervical mucosa exposed, and fairly firm and does not bleed easily; but just emerging from the os more to the right there are some large granulations, which upon being touched bleed easily and on pushing the probe into the cervical canal to right, it goes into some soft tissue that bleeds easily. Digital examination shows cervix very large at the attachment of the vaginal vault and hard, and a large section of the vault moves with cervix; the corpus and adnexa are normal in position, size and consistency. The diagnosis can be nothing but carcinoma of the cervical canal. The loop diathermy knife put into the cervical canal brings out a section of cervical mucosa with some of the more solid tissue. The pathologist reports adenocarcinoma of the cervix uteri.

The indicated treatment is clear. Surgery is out of the question because too much of the vaginal vault is involved, likewise electrocoagulation. Radiation is the only treatment to consider—at least 6,000 milligram hours, applied in the cervix, in the uterus and to the cervix, and vault of the vagina in such way as to get as much cross-fire as possible. This is what I call the initial treatment. If the deep x-ray machine is available this can be employed in such way as to reach the pelvic lymph nodes. However I do not think that lymph node metastases are very often cured by radiation, and it is my candid opinion that when cervical cancer has invaded the lymph nodes, that particular individual is doomed. After the initial treatment, these patients are observed every four weeks, and more radium applied as judgment indicates. What is the prognosis in such a case? I will answer: ultimately bad. The initial improvement will be splendid, and you may cure the original lesion, but in all probability she has lymph node metastases, and will succumb to these. The greatest good is done at the first treatment, and subsequent treatments require very discriminating judgment, otherwise you will be treating radium necrosis with radium.

It would lead too far afield to try to discuss the methods of treatment of the various locations of cancer. However, I will say that scaly and ulcerating lesions of the skin are usually best treated by radiation, but warty or mole-like growths by both radiation and excision. The same is true of the breast; really the latter is a modified skin gland. Malignancy of bones call for radiation and surgery, the viscera for sur-

gery. In lesions of the mouth no definite conclusion has yet been reached, but perhaps a combination of radiation and surgery is most often practiced.

I hope I have not been tiresome. My purpose is to try to get the men who first see these cases to follow a systematic method of investigation and to become cancer minded.

This is only a partial review of the writer's work, as many of the records were incomplete, and some could not be found.

The work is that of a country doctor and mostly on rural people and largely personal work, as only a comparatively few have been referred.

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DISCUSSION

Dr. J. M. Hoffman, Pensacola:

The paper by Dr. Turberville shows an exhaustive study of his cases. I am sorry that he was not able to show this chart. I believe that it would be worth while for every one interested in this subject to take a look at his chart. It really is a very comprehensive study of the experiences of the writer. It is only by this method of procedure that the final solution of these cancer problems will be worked out according to our present knowledge.

Dr. Turberville has mentioned only casually the etiology, and rightly so, because it is not definitely established in the mind of any of the authorities. My personal feeling is that we may have a low grade toxic factor to contend with. In passing we might notice the extreme preponderance of troubles being common in all cases. I don't believe that I have ever seen a case of cancer where pyorrhea was not also present.

In regard to the method of treatment: I feel that this is a matter of an entirely individual problem depending entirely upon the location and type of the tumor. The ideal treatment is a combination of radiation and surgery without too much stress laid on any one method. I am going over this rather hurriedly. We have not much time.

In conclusion I would like to state that my own feelings in regard to the man doing cancer treatment is—he should be competent. The man doing cancer work properly should be familiar with the microscopic and gross pathology of the lesion. Nothing can take the place of pathology. He should be able to read his microscopic slides as well as be able to read frozen sections. He should be entirely familiar with the principles of radiation therapy, not that he needs to give them particularly himself but he should be familiar with the technique. He should be familiar with the reactions that occur from radiation therapy, either x-ray or radium; and lastly, he should be thoroughly competent as a surgeon.

I want to thank Dr. Turberville for presenting this subject in full and giving it such exhaustive study from his own personal experience.

Dr. Gerry R. Holden, Jacksonville:

Dr. Turberville says that his work is simply that of a country doctor. Would to God that we had more country doctors like Dr. Turberville!

The problem of cancer is today possibly the most important public health problem which we have. It has increased enormously, as you all know, in the last thirty years. Heart disease is the only condition which causes more deaths than cancer. Tuberculosis, which thirty years ago was a major problem, is today actually a minor problem occupying sixth place in the list of diseases causing death.

For many years stress has been laid on the education of the public so patients will come in for an early diagnosis. I believe, gentlemen, that it is time to turn our thoughts toward ourselves and realize how important it is for us to make an early diagnosis when these patients do come in. Statistics show that the majority of cases go six or eight months before operation is done after they first apply for medical aid. This is not necessarily the fault of the medical profession, but it does bring out the fact that our present concept of cancer must be revised.

We, as a profession, must become cancer minded, and we must realize that the early symptoms of cancer in any organ are usually so slight that the average man is going to pass them over without realizing that the condition may exist. A few weeks ago I heard Dr. Chevalier Jackson talk about malignancies of the esophagus. He stated that if a diagnosis was made early the operation was simple as the condition progresses slowly. The majority of these cases could be cured. But he stated that practically every case of carcinoma of the esophagus is treated for some other condition for many months before a correct diagnosis is made. That, I believe, is

the case in the diagnosis of many malignancies. In the beginning cancer does not cause many symptoms, and it often resembles some minor benign condition with which the physician is familiar and which is usually easily cured. A brain tumor always gets treated for migraine first. Cancer of the tonsil is always treated for chronic tonsilitis. And you all know how many times cases of hemorrhoids are operated and found to be cancer of the rectum. We can go over any number of these lesions, and see how many a cancer in its incipiency simulates some minor condition.

How are we going to get around it? We cannot of course subject every patient that has some minor ailment to a thorough physical examination, but certainly we can do this: Whenever any one of these minor conditions does not easily and immediately respond to the ordinary treatment we can at once suspect cancer and put that patient through various examinations necessary to bar cancer. We can, in the general practice of obstetrics, follow up our cases and take care of these bad cervical lacerations. We can adopt in our office the simple method of transillumination of the breast which gives a great deal of information about these breast tumors. In cervical conditions we can apply Lugol's solution to the affected surface which will show us at once where to make our biopsy. In that way we can find early the cause of these cancer symptoms. Forty-seven per cent of all deaths from malignancies in women occur from these two conditions. If we can recognize them early and catch them before they are generalized we are going a great way toward controlling this enormous death rate in cancer.

CHORIOEPITHELIOMA*

BEN MANHOFF, M.D.,
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Chorioepithelioma is the term used to designate a rare neoplasm of the uterus, of a malignant type that arises from the epithelium of the chorionic villi. It usually occurs in association with the pregnant state; however, cases have been reported in the male arising from teratomas of the testes.

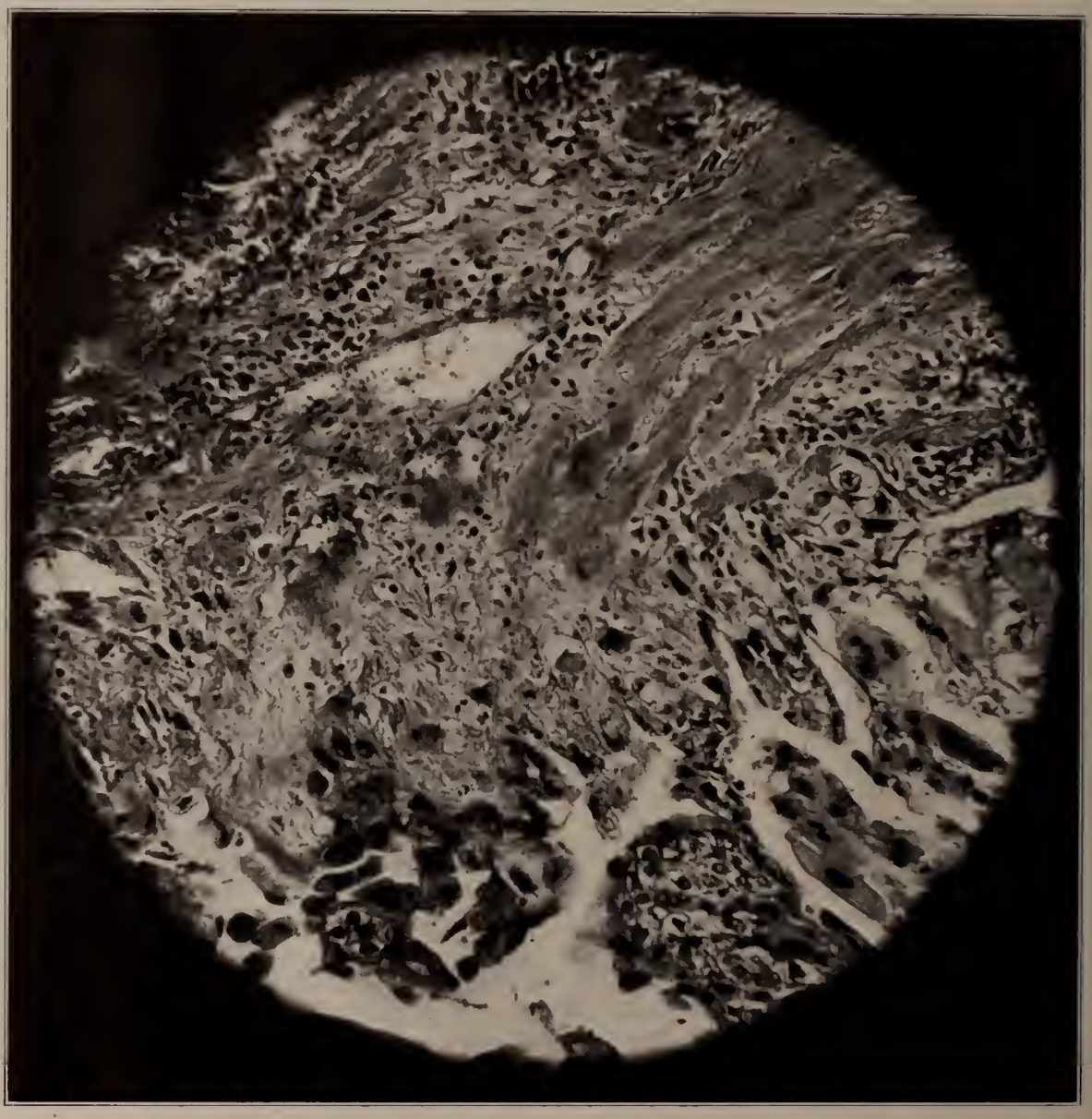
Although the diagnostic symptoms were first described less than fifty years ago, there had been only 571 cases found in the literature prior to 1931. At the Bellevue Hospital, over a period of eleven years with about 8,000 autopsies and 35,000 surgical specimens, only one case was revealed. At the Charity Hospital, New Orleans, in a review of records from 1910 to 1929, inclusive, only one definite case of chorioepithelioma was found. Dr. Arthur H. Curtis states that in a coordinated clinical experience covering a period of sixteen years, neither Dr. Watkins nor himself encountered a single case of chorioepithelioma, although they were constantly on the lookout for them. Undoubtedly, a number of cases were not published.

Saenger in 1889 was the first to describe the symptoms and diagnosis, and Marchand in 1895 demonstrated that the chorionic villi gave rise to these growths. Ewing has attempted to divide chorioepithelioma into three groups, (chorioadenoma, chorio-carcinoma and syncytioma). Novak recognizes only two chief forms, chorioma benignum and the chorioma malignum. The first of these is the benign hydatiform mole and the second is the commonly called chorioepithelioma.

The malignant growth occurs during the fertile age of the female. Multiple pregnancies appear to be a predisposing factor. Teacher reports that only 4.7 per cent of cases appear with the first pregnancy and the incidence rapidly mounts until approximately 38 per cent occurs in women who have borne five or more children. The statistics of Polloson and Violet and others show about 45 per cent were preceded by hydatiform moles, 30 per cent by abortion, 22 per cent by labor and 4 per cent by ectopic pregnancy. The frequency with which moles are transformed into chorioepithelioma has been based on conflicted data but recent investigators stated that less than 1 per cent of moles are followed by chorioepithelioma.

Two layers of epithelium cover the chorionic villi; the outer, termed "the syncytium" and the inner "the layer of Langhan", are both fetal in origin. A considerable proliferation of both layers takes place and prolongations of chorionic villi may extend deeply into uterine tissue. Such prolongations sometime become cut off from the parent villi or their cellular elements may get into the maternal blood. Whether the trophoblastic tissue pursues a malignant or benign course may be contingent on the presence or absence of a lytic substance in the maternal blood that offers a resistance and destroys in normal pregnancy those migratory chorionic cells which are at times found during pregnancy invading the uterine walls and at times found in the liver, lungs and other organs.

*Read before Staff Meeting of St. Vincent's Hospital, Jacksonville, Dec. 4, 1934.



Oscar Frankl has shown that certain substances in the maternal blood stream controls the formation of chorioepithelioma. He has demonstrated that serum of normal women during pregnancy is able to destroy fetal tissue from the placenta, while serum from women with chorioepithelioma does not possess this lytic action.

In these neoplastic growths the development of lutein cysts of the ovary is often found due to the increased secretion of anterior pituitary hormone. These cysts recede after the removal of moles or chorionic structures.

The most characteristic and prominent symptom is uterine bleeding appearing some weeks after abortion, ectopic gestation, expulsion of hydatiform mole or labor. This hemorrhage is usually profuse and may be alarming, yet, in many instances the bleeding may be comparatively slight, although protracted, simulating that which arises from retention of membranes or placental remnants.

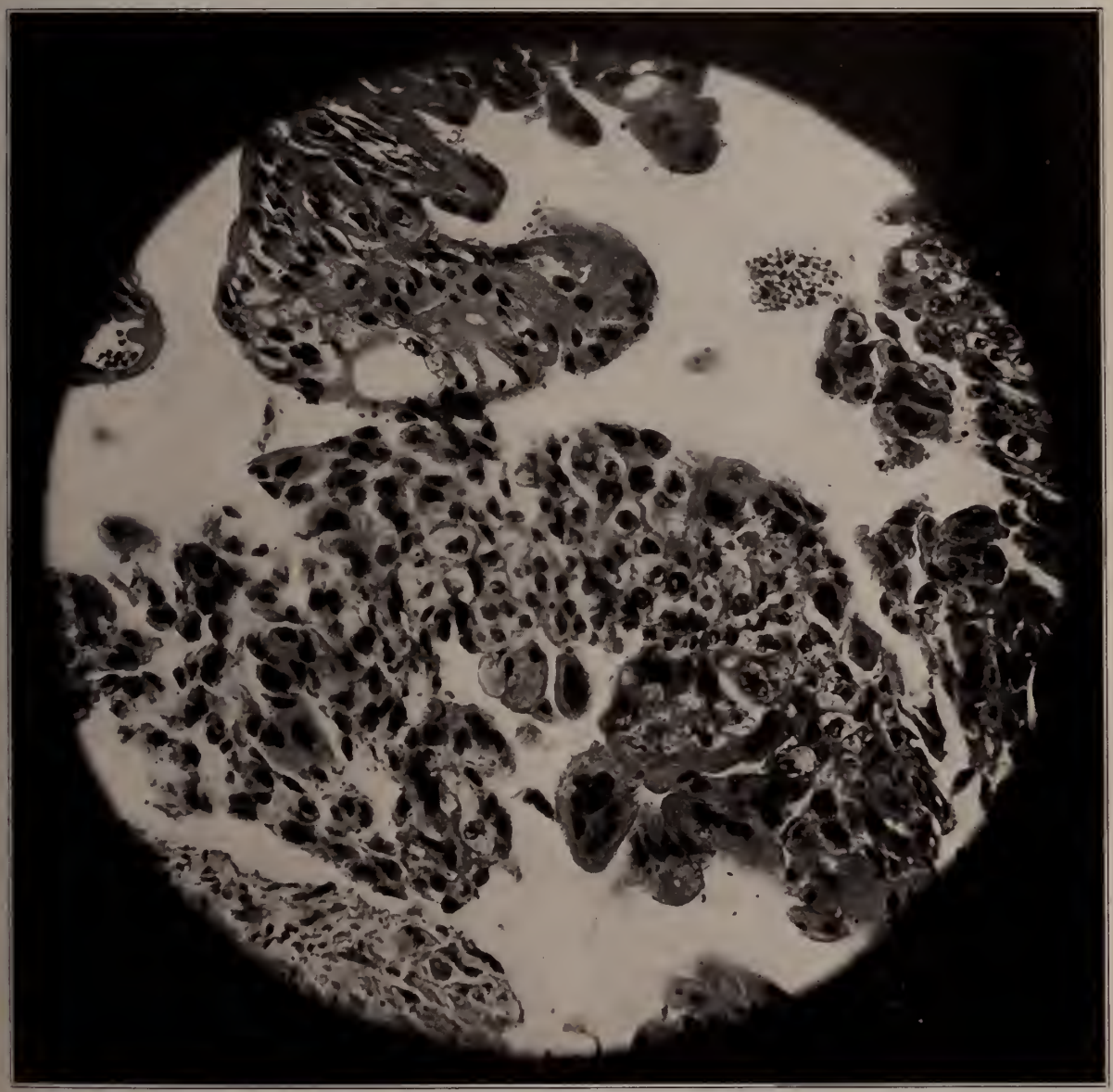
In a few cases intra-peritoneal hemorrhage has been responsible for the initial symptoms, in which the tumor in its growth perforated the uterus and simulated a ruptured tubal pregnancy. Suspicion of the presence of a chorioepithelioma should be aroused when a careful curettage is done and the bleeding recurs in about two weeks or does not cease at all. Rapid anemia follows soon accompanied by fever due to the peculiar

tendency of these tumors to infection. Occasionally uterine symptoms may be absent and the first manifestation of the disease may be symptoms from metastases. They are most likely to be present in cases with involvement of the lungs and often are diagnosed as pulmonary tuberculosis on account of hemoptysis, dyspnea and pain in the chest.

The uterus is somewhat enlarged, irregular in size, because of the site of the growth. The consistency, although usually normal, may be soft. At times objective symptoms may be offered by the presence of vaginal or vulvar metastases. They occur most frequently in the anterior wall near the urethral orifice and vary in size from an almond to a hen egg. They have a deep bluish color and appear very vascular.

The diagnosis of chorioepithelioma is based on the history, clinical symptoms and the microscopic examination. Diagnosis from curetting is exceedingly hazardous because the possible location of the tumor is often situated within the uterine wall and distant from the endometrium. The microscopic picture of chorioepithelioma is often closely mimicked by the benign hydatiform mole or even by normal pregnancy. Curettage increase the danger of disseminating the disease; also there is a danger of perforation at the site of the friable growth.

Since 1928 there has been added a most val-



uable diagnostic and prognostic laboratory procedure, the Aschheim-Zondek and the Freidman modification pregnancy test. Aschheim states that the pregnancy reaction in mice is twelve times stronger in a mole and chorioepithelioma than in a two month gestation. The reaction should not be regarded as a test for the presence of a living fetus but as indicative of active placental tissue or derivatives thereof. The constancy of a negative Aschheim-Zondek or Freidman reaction after abortion, expulsion of a mole or following hysterectomy for a chorioepithelioma is significant of a cure. A positive reaction might be interpreted as a continued proliferation of mole tissue, malignant degeneration or development of metastases, but Aschheim has shown that after the expulsion of a mole a positive reaction may continue for as long as two months without any evidence of chorioepithelioma. Consequently after removal of a mole or hysterectomy for chorioepithelioma the test must be conducted at regular two week intervals until a negative reaction is obtained then continued every four weeks for three or more months. Recovery may be pronounced if the negative reaction is maintained.

The treatment for chorioepithelioma is hysterectomy. Operation certainly seems contraindicated in the event of metastases, but in a few cases the phenomena of regression of metastases has followed hysterectomy. If the case is inoperable or a very poor risk, radium and deep x-ray should be employed. If malignant changes are permitted to occur due to the absence of some lytic substance in the mother's blood then theoretically giving the blood of a pregnant woman would be indicated as a curative agent in the treatment of chorioepithelioma.

REPORT OF CASE

Mrs. T. A. (Fernandina, Fla.), age 32, was admitted to the gynecological service of St. Vincent's Hospital, Aug. 14, 1934, complaining of vaginal bleeding which had continued for about six months. She has had seven children in nine years, the youngest being twins, age 5. About three years ago she had a miscarriage at four months. She had missed her period in December, 1933, but had not her usual symptoms of pregnancy, nausea, vomiting and soreness of the breasts. In the latter part of February she had a severe uterine hemorrhage, "passed a bucketful of clots and cauliflower-like growth" which she examined and as no fetus was present did not consider that she had been pregnant. The next bleeding began about March 17, 1934, and has been more or less constant—at times profuse, at other times rather scant. There were no other symptoms. She consulted her local physician in May who suggested that she probably had some retained membranes and advised her to submit to a curettage. As she did not consider she had been pregnant, no attention was paid to the physician's advice. During the latter part of July she noticed a soreness of her breasts. As there had been no definite let-up in the bleeding, at the earnest pleading of members of her family, she finally entered the hospital. There was no hematuria or hemoptysis. A general physical examination was negative. A pelvic examination revealed the lower genital normal in all respects. The cervix was enlarged, soft and the os was widely open. The fundus of the uterus was about twice normal size. It was of very soft consistency, to me it felt like a mass of putty. The broad ligaments and adnexa were normal. The bimanual examination started a considerable amount of bleeding. Next morning under an anesthetic in the operating room a sponge forceps was gently inserted into the uterus but no tissue was obtained; again hemorrhage was quite profuse. The abdomen was then opened. The pelvis was normal, there were no enlarged cysts of the ovaries. A right salpingo-oophorectomy and supra-vaginal hysterectomy was done.

Pathologic Report—Gross. The specimen is a uterus with grayish red friable material in considerable amount. The uterus is enlarged, smooth, symmetrical. Section reveals a ragged excavation in the upper cervix and lower part of the cortex. This extends in one place to within less than a cm. of the peritoneum. A tube is present. It is slender and congested. An ovary is small, slightly wrinkled and nodular with a few small cysts.

Microscopic Examination—The grayish red friable material shows microscopically masses of synctium with intensely staining nuclei, as well as giant cells with a single large stained nucleus. This atypical structure is burrowing into the muscle. The remainder of the endometrium is of normal appearance with few scattered glands. The ovary shows some small regressing corpora lutea and follicles near maturity.

Diagnosis—Chorio-carcinoma. Dr. C. E. Royce, Pathologist.

On the sixth post-operative day a Freidman test was reported feebly positive with undiluted urine.

The wound healed kindly. The patient had a normal convalescence.

On the tenth post-operative day the temperature suddenly arose to 102 and for the next sixteen days it ranged irregular between 100.4 and 103. On repeated examination and laboratory tests no gross abnormalities could be found. The patient during this interval felt perfectly normal and complained bitterly because she had to remain in bed.

On Sept. 14, one month post-operative, a second Freidman test was reported strongly positive with undiluted urine. On the same day the lung x-ray showed no metastases.

On Sept. 21, after the temperature had been practically normal for about eight days, the patient was discharged from the hospital.

On Oct. 31 the patient reported for another examination. During the interval she had gained five pounds. Examination was negative. There was no vaginal or vulvar metastases. Another x-ray of the chest was negative for metastases.

We were unable to obtain Freidman tests at regular intervals. The report of the last Freidman test made three and a half months post-operative was positive, a shade stronger than the previous test.

The prognosis is definite. Although as yet not located, metastasis is present. Following the operation deep x-ray or radium therapy was indicated but was not available.

COMMENTS ON CASE REPORT

The patient in February passed a hydatiform mole which has undergone malignant transformation and presented a textbook picture of chorioepithelioma.

Due to the shell-like character of the uterus it would in all probability have ruptured if curettage had been attempted.

As there was no involvement of the tubes, round or broad ligaments, and as the ovaries were not cystic, a bilateral oophorectomy was not done, because the ovaries are only secondarily involved by the anterior pituitary body.

The uterus was removed well below the site of the new growth. The profound anemia forbade a complete hysterectomy.

The temperature rise may have been due to a low grade sepsis superimposed on an anemic state caused by a moderate but prolonged bleeding.

Ewing states that he has been unable to find any record of cure of chorio-carcinoma following operation and most authors agree that chorio-carcinoma ultimately destroys the life of the mother.

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COUNTY HEALTH DEPARTMENTS*

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Achievements in the field of Public Health can be regarded as one of the most striking accomplishments of modern civilization. The measures provided for the improvement of the general public health have been remarkably successful and have produced phenomenal results in disease prevention and health promotion. The development of public health organization in this country has taken place largely within the past fifty years. About the middle of the past century the urgent need for instituting some measures for the protection of human life from the ravages of disease had become apparent to many of the leaders and organization-machinery designed for this purpose was slowly being formulated. Lack of definite scientific knowledge of the etiologic factors involved and consequently of the preventive measures necessary was an impediment to real progress. The epochal discovery by Pasteur of the role played by bacteria in disease causation and the many scientific discoveries which followed rapidly in the wake of his work supplied the essential knowledge upon which a constructive public health program could be fabricated.

Quite logically attention was given first to the thickly populated sections where such preventive

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measures were most urgently needed. City Health Departments for the protection of the citizens residing therein sprang up in rapid succession. Likewise the various states established health departments. Many of these Departments too often followed in the wake of some terrible epidemic. At the beginning of the 20th century all of the states and cities of any consequence had health departments of a kind. Many of them were grossly inadequate for the public health needs, yet they served as nuclei for future development. Prior to 1900 the chief activities of these departments had to do with the control of epidemics and general sanitation. The sanitation program consisted mainly of the purification of public water supplies and the installation of sanitary sewers. It is an interesting sidelight to note that the construction of sewers was primarily for convenience and not for real public health reasons —an idea too frequently encountered to this day.

In the South the chief activities of the health department of the states and large cities were designed primarily against yellow fever. As late as 1905 the State Board of Health of one southern state spent $40,000 for the control of this disease. It is interesting to note that a large percentage of this sum was paid for the employment of guards who enforced "shot-gun" quarantine procedures. In 1908 the annual expenditure by the Board of Health of one southern state was less than $10,000. With this meager appropriation no worth-while public health program could be expected. These figures are given to illustrate the status of public health in the South, less than a quarter of a century ago. Today the rural health work of some of the southern states is the pride of this country and an object of serious study by many countries of the world. What then has caused this transformation?

Progressive public health administrators had noted that following the creation and improvement of city health departments there had been an appreciable reduction in the morbidity and mortality rates in the areas thus affected and that the rates in the rural areas, which were considered more favored by nature, had not declined correspondingly. This observation was rather startling to a few and particularly to one, Surgeon L. L. Lumsden, who early manifested a desire to determine the factors involved in holding these rates at a level higher than could be expected if the then known principles of sanitary science were applied. As a result of his vision and recommendations, the U. S. Public Health Service made sanitary surveys during the years 1914-17, inclusive, of 17 counties in the United States to ascertain the essential data on the health of the people of the rural areas. In 1910-14 the Rockefeller Sanitary Commission engaged in a South-wide campaign for the eradication of hookworm disease. This campaign reached practically every county in the South. These two programs constituted a gigantic public health educational campaign. The seeds of a real constructive public health program were sown by these pioneers. Some of these seeds fell on stony ground, but many fell upon fertile soil and sprang up and brought forth fruit, now being utilized by the modern public health workers.

These two agencies in cooperation with official health organizations of quite a number of states during recent years have striven earnestly to ascertain how best to safeguard the health of the distinctly rural population. Many unofficial philanthropic agencies have made similar investigations. It is rather striking that practically all of these agencies waging highly specialized campaigns in different fields should have arrived at practically the identical conclusion, viz., that the public health of a distinctly rural population can be more adequately and economically conserved through the agency of a full-time local health service than through any other means. In the Southern States the county was found to be the logical unit. These highly specialized campaigns demonstrated the need for some local organization manned by full-time well-trained personnel on a permanent basis which could properly correlate and integrate the various phases of a sensible public health program. In this way the full-time county health movement had its beginning in 1911—less than a quarter of a century ago! Yet in that short time the feasibility and the effectiveness of this service has been thoroughly established. Effective county health service has focused the attention of public health administrators in various countries of the world on some of the Southern States and representatives from many foreign countries have visited those states for the purpose of studying at first hand, the methods therein being used.

The whole-time county health department may be defined as an official organization composed of at least three persons, one a physician, all of whom are well trained in public health, who devote their entire time to the task of preventing disease and promoting health. This is the minimum organization. The size of the department

and the number of personnel will be limited by the willingness of the people to appropriate money for health protection. The question then naturally arises: what are the duties and functions of such an organization? A very striking illustration was given the writer some years ago by a Chinese physician who was taking post-graduate work in public health when he said, "Doctor, the State Board of Health may be likened to the human body and the county health department to the hands and feet. Cut off the hands and feet and the State Board of Health is hopelessly crippled." In truth it is through the county health department that the highly trained personnel of the central organization can render their largest service. With such an organization clearly in mind it is deemed advisable to outline briefly some of the activities of a local health department. These activities have been routinely carried on and reasonably can be expected to be executed by any full-time county health department.

1. *Public Health Education:* The bed-rock of any public health campaign is education. The success of public health work depends largely upon the character of the education program executed. It is often necessary to replace misinformation and superstition with correct information. A successful educational program does not merely impart correct information, but implants or creates a desire among the people to make practical application of the information thus obtained. The old order in public health with its superstitions, false theories, shotgun quarantines, and fumigation must give way to the new public health which depends for its complete fruition upon scientific data, common sense, and an enlightened public opinion.

By all the known methods of imparting information to the general public, such as lectures often illustrated with motion pictures, newspaper articles, letters, charts, health bulletins, and personal conferences, an effort should be made to teach the people the essentials in disease prevention and health promotion. The following facts relative to contagious diseases should be stressed: (1) The vast majority of the contagious diseases from which human beings suffer have their origin in other people: (2) the causative agent of most of these diseases occurs in the secretions from the nose, throat, and lungs, or in the discharges from the bowel and kidneys of people afflicted with the particular disease in question or of a "carrier"; (3) in order for a well person to contract one of these diseases it is necessary for that individual to take into the mouth in a fairly fresh state some of the infected secretion or excretion of another individual; (4) the prevention of these diseases resolves itself simply into the avoidance of the secretions and excretions of other people by adhering strictly to a few common sense rules of personal hygiene; and (5) the proper disposition of all of the secretions and excretions of the human family is essential for the physical well-being of the race. The practical methods of preventing most of the communicable diseases should be explained to the people in terms which are readily understandable and capable of being assimilated.

As a result of a well-planned and effectively executed common sense educational campaign the people can be made "health conscious" and can be induced not only to know the factors embraced in personal hygiene and public health, but to inculcate these principles into their daily lives in the form of correct health habits. This is the ultimate aim of the public health educational program.

2. *Control of Communicable Diseases:* The fundamental purpose of creating and maintaining whole-time local health departments is to reduce the incidence of communicable diseases, and any health department which fails to accomplish this is not functioning properly. This is accomplished by locating and isolating active cases and "carriers", quarantining the contacts, giving detailed instructions in bedside preventive measures, and if the disease happens to be one for which a specific immunizing agent has been developed, making liberal use of the immunizing agent among the contacts. This procedure is followed when the disease actually occurs, but an efficient health department endeavors to anticipate the occurrence of these diseases and takes the necessary steps to prevent this occurrence. Thus if a public water supply is found, upon examination, to be contaminated, the wise health officer does not bide his time and await the development of an outbreak of typhoid fever or dysentery before acting, but takes immediate steps to remove the potential danger and thus prevent a possible epidemic. Eternal vigilance practiced by one skilled in the principles of sanitary science and preventive medicine is essential for the proper control of contagion.

3. *Maternity Welfare Work:* A well-rounded public health program embracing such activities as the improvement in the public and private

water and milk supplies and the methods of excreta disposal, screening of homes, safeguarding food supplies, and the eradication of mosquito and fly breeding places will undoubtedly improve the health conditions of the mothers and infants. However, there are factors which have a special bearing upon the health and welfare of the mother and child and these merit particular attention of health workers. When it is known that a large percentage of the mothers of the Southern States do not have the services of a physician at the birth of their children, but have to depend upon superstitious midwives many of whom do not realize the necessity for even soap and water cleanliness, the magnitude of this problem becomes apparent. In the local health departments an effort should be made to teach these midwives the necessity of strict cleanliness; the danger signals to be watched for in an expectant mother; the danger of needless meddling with obstetrical cases at the time of confinement; and the absolute necessity of calling a physician in all abnormal cases. The main purpose of this instruction to the midwives is to render their services least harmful to the public health.

In maternal and infant welfare work the services of a well-trained public health nurse are invaluable. Such a nurse has the ability to convey in an appealing way to the expectant mother the essential scientific facts which every expectant mother should know in order that she might pass through this trying period of her life's history with the greatest safety. These mothers should be taught the essentials of correct diet, proper hygienic care of the body during this period, and the necessary preparations which are to be made for the lying-in period. The aim which the local health department should strive to accomplish in dealing with expectant mothers is to get them early into the hands of competent physicians, thereby decreasing the demand for midwives.

4. *Infant and Pre-school Work:* Routine medical examination of school children has revealed the fact that many of the defects encountered during these examinations had been in existence for some time prior to the entrance of the child into the school and should have been corrected earlier in life. This discovery has emphasized the necessity for routine examination of infants and pre-school children. Special stress should be placed upon this phase of work in practically all of the local health departments. Child health demonstrations may be held at regular intervals where infants and pre-school children can be given a thorough physical examination for the detection of physical handicaps. The defects found should be pointed out to the parents with the request that immediate attention be given to their correction.

5. *School Work:* Of all phases of public health work the regular medical examination of school children no doubt holds first place in general popularity and far-reaching effects. As a means of public health education it takes first place. In carrying out the public health program in the schools the whole-hearted cooperation of the teaching profession can be expected. To no group has the value of this work been more forcibly illustrated than to the teaching profession. Teachers have fully realized the effect that physical handicaps are likely to produce as a deterrent to mental development. The school children should be regularly examined for physical imperfections which are considered likely to interfere with their physical and mental development and may later become the actual cause of a disease process in the child's body. These defects should be noted and the parents or guardians informed of their presence and especially urged to have the correctable defects remedied. The actual work of correcting these defects is not a function of the local health department, but must be taken care of by the medical and dental professions. In some counties it is impossible to examine the entire student population during each school year. In such counties after one thorough physical examination has been made, subsequent examinations of the first, third and fifth grades will suffice. School work is tedious and time consuming yet the results achieved in improvement in the physical welfare of the children and in the dissemination of sane public health information is considered adequate compensation. In fact it is felt that the results which can be accomplished in this particular phase of public health work can be regarded as ample justification for the entire expenditure of public funds for local full-time health service.

6. *Environmental Sanitation:* A health department which fails to make an appreciable improvement in environmental conditions in the territory over which it has supervision is not fulfilling the chief function for which it was created. It is the function of the local health department to make surveys of thickly populated sections for the purpose of determining the safety of the water and milk supplies, the possibility of mosquito and fly breeding, and the safety of the methods of

excreta disposal; to recommend to the proper authorities the necessary measures for the correction of existing evils; to supervise such corrective work and to see to it that such work is done in accordance with standard methods of procedure. It is folly for the health department to engage in the niceties of the public health program and neglect the fundamentals. It is nothing short of a tragedy to relieve a child of all of its physical handicaps and then allow that child to die of some communicable disease occasioned by a failure in the general sanitation program.

In the Southern States no one phase of public health work will exert a more beneficent influence on the general health tone of a community than that of properly disposing of human waste matter. The filth-borne diseases, namely: typhoid fever, hookworm disease, dysenteries, and diarrhea, are still too prevalent in this area. It is a well-known fact that most of these diseases are caused by the ingestion of improperly disposed of human excreta. Increasing stress must be placed upon the proper disposal of this potentially dangerous matter until the open back privy, which has been very properly designated the "Typhoid Temple", shall have been banished. As long as these devices continue to exist this group of diseases will continue to exact a needless toll of human life.

From this brief and sketchy resumé of the activities of a full-time county health department it can be readily seen that the services of active, well-trained, conscientious and enthusiastic personnel are required to effectively execute such a program. The need for permanence is also apparent. The whole public health program, to be effective, must be based upon reasonableness and common sense. Care should be exercised always in order to avoid highly specialized campaigns. Mention is here made, merely to condemn them, of the spectacular measures which are sometimes utilized by some health workers. The need for spectacular demonstrations in public health has passed, if it ever existed. It is the well-planned routine program, executed from week to week and from year to year and not sporadic, highly specialized demonstrations which must be relied upon to produce permanent and effective results in public health work. In the future the efficiency of the public health program of any state will be judged not by the size and activities of the central organization, but by the percentage of the citizens of the state who are adequately served by an efficient local health department. Therefore, let the members of this conference become active crusaders for the creation and maintenance of full-time local health departments through which the measures essential for the protection of the health of people of this state may be applied in a logical sequence and in proper relation one to the other. This is a large undertaking fraught with grave responsibility, serious obstacles, and many difficulties, yet it is felt that it is a cause which merits your most careful consideration and determined effort, and if pushed to a successful conclusion will cause the children of future generations to rise up and call you blessed.

THE EARLY HISTORY OF VACCINATIONS AGAINST SMALLPOX IN THE SOUTHEASTERN PART OF THE UNITED STATES*

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Before proceeding with my account of early local vaccinations, I wish to make a short statement explaining and perhaps justifying my selection of this subject. In the first place, no account of early vaccinations in this part of the country has ever been written, so far as I have been able to discover. In truth, the facts needed for such an account were so scattered that it would have been difficult to write an adequate history. Recently there has come into my hands, through the courtesy of Miss Susie M. Kollock, of Atlanta, a series of about 80 letters, written by, and to, a Savannah physician, Dr. Lemuel Kollock, and covering the period from 1792 to 1822. These letters contain information of an interesting character concerning vaccination in Savannah and neighboring communities. I have supplemented this information from other sources.

To my surprise and gratification, I find that vaccination was introduced in this part of the country very promptly after the publication of Jenner's discovery, and soon after its introduction into the larger cities of America. Inasmuch as our local cities were still quite small in 1800—at the time vaccination was first introduced into America—it is gratifying to learn that the small groups of doctors in these communities were so well-informed and progressive. For Savannah at that time was only a city of about 3,000 people, a considerable proportion being negroes.

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Sunbury, now known as one of the dead, or non-existent, towns of Georgia, was even smaller, having declined in population on account of the devastation resulting from British occupation during the Revolutionary War. Midway was a rural community with only a roadside church and store. Charleston, alone of the communities considered, was a considerable city (population 19,000), with a long history and cultural background, and a distinguished and well-organized medical profession. This City of Jacksonville, where we are meeting, with its beautiful homes and busy wharves, was practically non-existent, being only a transitus vaccarum, or place of cow-crossing on the St. Johns River. (This helps us to remember that the year 1800 was a long time ago).

My second reason for selecting this subject is that I am a firm believer in the value of an understanding of the historical development of a subject, both in securing and applying knowledge, and, perhaps, especially in the latter. I know you will agree with me that the greatest achievement ever made in preventive medicine was Jenner's discovery of a practical method for controlling smallpox—that great scourge of mankind. The successful application of this method in any community constitutes a great demonstration in health protection. I trust, further, you will agree with me when I have presented this subject that the history of vaccination in this part of the country, and, perhaps, especially in Savannah, throws light on the development of public health in the communities mentioned.

It is a great mistake to live too much in the past, especially if carried to the point of neglect of the present. Many of our people are inclined to that error. It is equally an error to neglect the past, especially in scientific inquiry. No complete and comprehensive understanding of a science can be secured, if its history and development are ignored. Especially is this true of medicine, which is both a science and an art. My greatly revered teacher of medicine, Dr. Wm. Osler, of Johns Hopkins, placed great emphasis on the value of the historical method in studying disease. Even more so is it true that the practical branch of medicine known as public health is best understood when examined from an historical standpoint. Attempts to improve and standardize public health, which neglect the historical element, frequently fail to achieve the best results. Possibly the technical side of public health could be standardized without reference to historical knowledge, but the practical application of such standardized methods is inevitably deeply influenced, and sometimes materially limited by the mass psychology of the population to be served. The attitude of a community towards public health is largely determined by its history. If that is conceded, it is evident that the public health programs of different communities will inevitably differ considerably, and that the best results in any community can be obtained only where plans are made by persons acquainted fully with local history.

I will attempt to give briefly the facts concerning the history of vaccination in South Carolina and South Georgia, and show, especially in the latter area, the influence of that early work in preventive medicine on the medical and public health history of the community.

There is an old saying that it takes twenty years for a new discovery to come into general use. There are two difficulties in applying this maxim. One is the difficulty of determining the exact time when a discovery is made, since frequently, indeed, in the majority of cases, the process of discovery is gradual, and often several investigators working over a considerable period of time participate in the final result. The second difficulty is that of deciding just what constitutes general acceptance of a discovery. In Jenner's case, if the date of his first publication be taken as the time from which to begin to count years, and the general recognition by the medical profession and their use of his discovery, as the end of the period of probation, it must be granted that the old maxim did not hold good, since the recognition of the value of vaccination was remarkably prompt, and its acceptance by the medical profession was widespread and general, though not at once unanimous.

Jenner got his first information concerning the possibility of the disease cowpox protecting against the disease smallpox, from a Gloucestershire milkmaid in 1787. The story she told was similar to many of the fairy stories concerning the wonderful curative powers of popular remedies common to our folk-lore and especially common among our negroes. It aroused the curiosity of Jenner. With a persistence uncommon, he continued to collect information concerning cowpox and its relation to smallpox and to seek for an opportunity to make an experimental attempt to use cowpox to produce the protection against smallpox claimed. Not until 1796 did he find an opportunity. Then, as in all the early

vaccinations, the efficacy of the vaccination was at once tested by inoculation with smallpox itself. A boy, named James Phipps, was vaccinated with cowpox on May 14, 1796, and had a typical reaction. On July 18th, he was inoculated with virus from a smallpox patient, and proved to be immune to the disease.

By 1798 Jenner had vaccinated 23 people; all proved to be immune to subsequent variolation. Jenner then made his first publication, and, in the next eight years, issued five successive pamphlets telling of fresh successes, and of the improvements in the technique of vaccination, and in the securing, storage and handling of vaccine virus.

The news of the new discovery spread rapidly. Certain circumstances favored the rapid progress of its adoption. In the first place, smallpox had long been, and still was, a greatly feared and highly fatal disease, the mortality as high as 20 per cent or even more at times. It was especially a disease of children, hardly a child surviving early life without scars of the disease. It was a disease of the wealthy, as well as of the poor, no ordinary precaution sufficing for protection. It was widespread. It was not limited to certain sections as was yellow fever and malaria. Secondly, the way for acceptance of vaccination had been prepared by smallpox inoculation. The methods were similar. Protection by cowpox was quite as complete and certain, at least for a term of years, as the protection secured by inoculation. Variolation—as smallpox inoculation was called—had two great objections. In a considerable percentage of cases, the disease did not remain local, but became generalized, frequently with fatal result. While the fatality from inoculation was much less than that from the disease itself, it was usually at least one to three hundred, and sometimes as high as one to fifty. This mortality had been reduced by proper methods of inoculation. At first long incisions were made, or the virus actually introduced into the veins. Later, in England, the Drs. Sutton used and recommended the insertion of the virus by puncture into the skin with lancets or needles, somewhat similar to the intradermal method of cowpox vaccination now used. This Suttonean improvement resulted in a lessened fatality from variolation and was introduced into Philadelphia by Dr. Benj. Rush shortly before the Revolutionary War.

Smallpox inoculation gave protection. It was preferable to the disease occurring in the natural way, but was feared for its possible fatal results. A suitable substitute was welcomed.

The second objection to inoculation was that, even if the pock resulting remained single and local, the person actually had smallpox, and could transmit the disease to others. Not only were individuals infected, but small epidemics actually occurred in this way. As a result, inoculation was preferably practiced in smallpox hospitals, where patients were carefully isolated. Its practice was often forbidden, except by court order, and, as vaccination become known to be a preferable method, inoculation was finally and completely forbidden by law.

These considerations also made the news of vaccination welcome, and the information was rapidly spread through publication in medical journals, through pamphlets, by correspondence and by travelers. A review of the subject was printed in an European journal, *Annals of Medicine,* as early as 1798, but probably did not reach many American physicians. The first notice of Jenner's discovery in an American medical journal appeared in the *Medical Repository,* in December, 1798.

The method was promptly introduced into Europe. One of the letters, which I will read, tells of a request from France that a competent person, knowing the new method, be sent from London to Paris. The method was thus rapidly spread on the continent of Europe.

We are more concerned in knowing how soon vaccination was practiced in America. Boston was then a great center of general culture and medical learning. In July, 1800, Dr. Waterhouse, of Harvard University, received virus from England and made the first vaccination in America. In quaint Yankee phrases, he told of the new method of protection in a local journal, characterizing it as "Something curious in the Medical Line." During the same summer vaccinations were made by John Crawford, in Baltimore, and, during the next year or so, in Philadelphia and New York. The demand for virus caused the establishment of a Vaccine Institute in Baltimore, by James Smith, in 1802, and a National Institute was founded by Congress in that city in 1813.

From the information now available concerning the beginning of vaccination in Savannah, I am inclined to think that perhaps the earliest vaccinations in the Southeastern part of the United States were made as early as June, 1801.

Perhaps information of an earlier date of the use of this method, will sometime be discovered.

Information of the new method must have been available soon after 1800, or perhaps even sooner. On the first day of the new century, Dr. David Ramsay, of Charleston, had been invited by the South Carolina Medical Society, of his city, to give an address on the "Improvements in Medicine in the 18th Century." Copies of this address are rare, but a very complete review was given in the *Medical Repository* by Dr. Mitchell, its editor. Dr. Ramsay discussed the improvements in the treatment of smallpox and other fevers, and praised the value of smallpox inoculation, but did not mention vaccination. Either he had not heard of the new method, or did not consider its value established, probably the latter, since, by pamphlets and correspondence, news of the method was then being spread.

The first known communication on the subject to Savannah was from a young medical student in London, Dr. Horace Senter, who was walking the hospitals of London in company with Dr. John Collins Warren of Boston, and other bright and promising young American medical students. Dr. Senter was the only remaining son of Dr. Isaac Senter of Newport, the Revolutionary patriot and friend of Washington and Greene.

Dr. Horace Senter corresponded with Dr. Lemuel Kollock of Savannah, who had been a student of medicine, living with the family of Dr. Isaac Senter and acting as tutor to young Senter. Under dates of May 20th and July 10th, 1800, young Dr. Senter wrote his father's friend and disciple, Dr. Kollock of Savannah. The first letter was brief and stated only that cowpox inoculation and treatment of pulmonary tuberculosis with digitalis, then a new method under observation, were points of chief interest to the medical profession in London. In answer to Dr. Kollock's request, the second letter gave a little more information about cowpox vaccination. Young Senter wrote, "You wish to know something of the Variola Vaccine. All I know is that it is supposed by great men here to be far, very far, preferable to the smallpox (inoculation), and that it must supersede the latter. The French have sent for Dr. Woodville of London, to go to Paris to give them some particular instruction and advice respecting it. He is gone there. Others have gone to Germany and Italy." Young Senter completed his three years of medical study in the fall of 1800 and returned to America, settling in Newport, and following in the footsteps of his celebrated father who had died the previous year. It is quite likely that Dr. Horace Senter brought back with him, from England, a supply of cowpox virus for inoculation, but we have no exact information of this. All we know is that in the succeeding year, Dr. Kollock had a supply of virus and was making vaccinations in Savannah. The succeeding history of young Dr. Senter is tragic; his most promising career was ended when he died from tetanus following a duel in Savannah in the year 1803. His death notice is one of the earliest formally recorded in our city records.

Dr. Lemuel Kollock, the recipient of this early information, was a highly intellectual and progressive physician, a native of Wrentham, Mass., where he was born, of Huguenot descent, in the year 1766. After a good classical education in Brown University, he studied medicine under Dr. Isaac Senter, Newport, as preceptor, and finally settled in a small city in South Carolina. In 1792 he began practicing medicine in Savannah, and remained thus engaged in general practice until his death in 1823. He was the first of four physicians of that name who served the people of Savannah for nearly 100 years, especially giving loyal service in the great epidemics of 1820, 1854, and 1876.

Dr. Kollock's letters show him to have been an ardent student of medicine. Medical knowledge was spread more by correspondence in that day than now; less by medical journals and travelers. Only one American medical journal existed, the *New York Medical Repository*, established in 1796. For this journal Dr. Kollock was an active volunteer agent, and many of his letters are from Drs. E. H. Smith and Edward Miller, editors of the *Repository*. His letters also show that he was constantly receiving books, both on medicine and general science. Among his many distinguished correspondents and friends, was the celebrated doctor and author, Dr. David Ramsay, Revolutionary patriot, and one of the leading physicians of Charleston, S. C. Dr. Ramsay's address to the South Carolina Medical Society has been referred to, and the conclusion drawn, that either he did not know of cowpox vaccination, on Jan. 1, 1800, when the address was delivered, or that he did not consider the new method worthy of comment. Early in 1801 a letter from Dr. Ramsay establishes the fact that vaccination was being performed in Charleston, in Savannah, and at Midway, Ga., at that time. The letter is addressed to Dr. Kol-

lock, Physician, Savannah, and the following note inscribed on the folded sheet with the address, "With a black boy, which boy and this letter are to be sent to Dr. Kollock immediately on the arrival of Captain Lonyers."

The letter is from Charleston, and is dated June 11, 1801. That part of the letter which has information on vaccination is as follows: "I am not satisfied that the cowpox has taken in any one instance. None of my patients has had a sore arm from the insertion of the matter. Some have had fever and eruptions, but like nothing I was acquainted with. The affection of the axilla was also wanting. I have, therefore, determined to send a subject for the purpose of being inoculated with the cowpox and bringing the matter fresh in his arm. I have, therefore, to request that you insert the vaccine matter freely into both arms of the negro boy who accompanies this, and that you send him to me by the stage or by water (if a good opportunity offers) as soon as you are certain of his being infected with the disease. Please to put him under the protection of some decent passenger or captain. Mr. Fabian is now here, who doubts the existence of the cowpox in Savannah, and recommends in this case the boy be sent on to Midway. I trust to you to have the business done effectually, so that I may confidently proceed to inoculate from the boy soon after his return. Mr. Fabian will pay all expenses that may be necessary for the boy's maintenance or passage. I am so partial to the Cow Pox that I plan to inoculate my own son with it. My attempts with the thread you sent me have failed, but I mean to persevere."

This letter seems to establish the fact that vaccinations against smallpox with cowpox virus were being performed in Charleston, Savannah, and Midway, Ga., at least as early as June, 1801. It will be noted that Dr. Ramsay states that he had not succeeded in his vaccinations.

From other sources, it is known that Dr. Adam Alexander, of Sunbury, Ga., adjacent to Midway, was performing vaccinations against smallpox prior to 1802. I am indebted to Dr. Thomas Boggs of Baltimore, his descendant, for the information and for a reproduction of a miniature portrait of Dr. Alexander in his early years. Dr. Alexander was born in Scotland, in the year 1758, and came to America in 1776. He served as surgeon in the Revolutionary Army, and, after the war, settled in Sunbury. It is undoubtedly Dr. Alexander who is referred to in Dr. Ramsay's letter as making vaccinations in Midway in 1801. If the cowpox did not exist in Savannah in June, 1801, we may be quite sure that the negro boy was sent to Midway, properly inoculated in both arms, and returned to Dr. Ramsay in Charleston, but no further records are at hand (except Dr. Alexander's journal).

A record of vaccination on April 28, 1802, is found in the journal of Dr. Moses Sheftall of Savannah, in which a charge of $6.00 is recorded for vaccinating Rachel and Reuben Jacobs, probably son and daughter of Mr. Abraham Jacobs of Savannah. Dr. Moses Sheftall was a leading practitioner of Savannah (descendant of a colonial family), and active in many civic duties. He was health officer of the city in the years 1800-1802, and in charge of the first smallpox hospital, founded by the city in 1800. For many years, in later times, he served as alderman of the City of Savannah. He was undoubtedly one of the earliest users of cowpox for vaccination. He was the leading member of a family of physicians.

In 1804, Dr. Kollock and Dr. Sheftall, with twelve other Savannah physicians, founded the Georgia Medical Society for (its purpose as stated in its charter) "the purpose of lessening the fatality induced by climate and incidental causes, and improving the science of medicine." This Society is now the second oldest active city medical society in the United States. Its first president was Dr. Noble Wymberley Jones, the Georgia patriot—"The Morning Star of Liberty in Georgia." One of the first duties of the new society was to provide for a topographical health survey of the city and to make provision to prevent epidemic diseases. In 1805 the first official notice of vaccination occurs in the city records, the Mayor noting that the doctors of the city had received a supply of virus and had offered to vaccinate all who offered themselves.

In 1816 vaccinating was made compulsory in Savannah for the first time and in 1843 provision was made for revaccination every nine years. At present our community has a statute requiring vaccination in Chatham County, and an ordinance requiring successful vaccination, with revaccination every seven years, in the city. This is in addition to the usual regulation of the Board of Education, requiring vaccination of school children. Few communities in the South have, or enforce, compulsory vaccination laws, and, so far as I know, no other community in

Georgia has such a law, though many have regulations of Boards of Education, which have, however, serious legal limitations.

Many years later, a Savannah physician, born in Liberty County, Georgia, made one of the most thorough and complete studies of the accidents, complications and sequelae of vaccination ever recorded. I refer to Dr. Joseph Jones, in later years Professor of Medicine in Tulane University.

Thus within 20 years after the control of smallpox was begun, the Georgia Medical Society of Savannah, long before the formation of the Medical Association of Georgia, or of the American Medical Association, in addition to forming a medical organization, adopted a system of medical ethics, secured the passage of a medical license law for our local community, established a medical library—one of the oldest in the country—and adopted effective measures to reduce malarial fevers, the first antimalarial work in the United States. The study of the history of the organization makes it clear that much of this particular work followed as the direct result of the successful work of controlling smallpox by the newly organized profession in early days by Jenner's new method. Our doctors have always taken a large interest in public health. Eight of the members of our Medical Society have served as Mayors of the City of Savannah over long periods. Thirty-two members of the Medical Society have served as aldermen of the City, and it is now a custom by unwritten rule, to include at least one doctor on the aldermanic board. This custom, and the participation of our physicians in all the civic interests, including especially those related to public health, have resulted in much health progress, and have given us a community which is health-minded.

Thinking, possibly that I might find an earlier record of vaccination in the records of the South Carolina Medical Society, I have recently examined, with the kind permission of Dr. Wm. Atmar Smith, Secretary of that organization, the minutes of that society, from its founding in 1789, to the year 1806. The earliest record of vaccination recorded in the minute books of the Charleston Society was reported by Dr. Frederick Dalcho, in July 1802. It is probably for reasons already given therefor that the earliest vaccination in Charleston was made by Dr. Ramsay in or about June 1801. Possibly other records will in time be found of earlier dates.

In 1802, and again in 1805, the physicians of the Charleston Dispensary, by request of the South Carolina Medical Society, made publication in the local newspaper, giving information about vaccinating, and highly recommending the same to citizens of Charleston. The publication in 1805, stated to be identical with that of 1802, was signed by all physicians attending the clinic, about 12 or 15 in number, headed by Dr. David Ramsay.

The South Carolina Medical Society, of Charleston, has sustained much the same relation to the development of public health in Charleston, as the Georgia Medical Society has in Savannah, though not so many of its members appear to have served in the capacity of city officers. In each city the early work of the organized profession in using vaccination to control smallpox, has been followed by a long series of activities in support of Public Health, and has greatly influenced public opinion.

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THE CITY OF JACKSONVILLE

EXTEND TO

THE MEDICAL PROFESSION AN INVITATION TO ATTEND THE

SIXTH ANNUAL ASSEMBLY

OF THE

SOUTHEASTERN SURGICAL CONGRESS

TO BE HELD IN

JACKSONVILLE, FLORIDA, MARCH 11, 12, AND 13, 1935

HOTEL MAYFLOWER

This is an unusual opportunity for the members of the Florida Medical Association to enjoy the privileges of one of the best postgraduate medical meetings held in this country. Those appearing on the program are outstanding men of national and international reputations. In addition to the papers, there will be numerous clinics held by visiting physicians.

Each visiting doctor is requested to register immediately upon arrival, at the booth in the Hotel Mayflower lobby. A registration fee of $5.00 is charged to help defray the expenses of the Assembly.

A delightful entertainment program for the ladies has been arranged.

PLAN TO ATTEND THIS MEETING

(OVER)

The scientific session will begin promptly at 8:00 o'clock Monday morning, March 11, on the roof garden of the Hotel Mayflower. The following will appear on the program:

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Rochester, Minn.

Baggett, L. G.
Atlanta, Ga.

Ballenger, Edgar G.
Atlanta, Ga.

Bigger, I. A.
Richmond, Va.

Bodley, James W.
Memphis, Tenn.

Cabot, Hugh
Rochester, Minn.

Campbell, Willis C.
Memphis, Tenn.

Clifton, Ben Hill
Atlanta, Ga.

Crile, George
Cleveland, Ohio.

Douglas, Gilbert F.
Birmingham, Ala.

Erdmann, John F.
New York, N. Y.

Flothow, Paul G.
Seattle, Wash.

Greene, Ralph
Jacksonville, Fla.

Haggard, William D.
Nashville, Tenn.

Harper, W. F.
Selma, Ala.

Hertzler, Arthur E.
Halstead, Kansas

Horsley, J. Shelton
Richmond, Va.

Jackson, Chevalier
Philadelphia, Pa.

McKnight, R. B.
Charlotte, N. C.

Miller, C. Jeff.
New Orleans, La.

Mims, Gage
New Orleans, La.

Moore, Chalmers H.
Birmingham, Ala.

Ochsner, Alton
New Orleans, La.

Patterson, J. C.
Cuthbert, Ga.

Philpot, V. B.
Houston, Miss.

Scruggs, William Marvin
Charlotte, N. C.

Simpson, J. Knox
Jacksonville, Fla.

Snyder, J. W.
Miami, Fla.

Taylor, H. Marshall
Jacksonville, Fla.

Watson, Jerre
Anniston, Ala.

Weldon, William A.
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Greenville, S. C.

PLAN TO ATTEND THIS MEETING

(over)

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GRADUATE SHORT COURSE FOR DOCTORS OF MEDICINE IN FLORIDA

The Medical Post-Graduate Course Committee, appointed by the Florida Medical Association to have charge of the third Short Course for Doctors of Medicine in Florida, met with Dean B. C. Riley of the General Extension Division of the University of Florida and W. K. Mitchell, Secretary of Institutes and Short Courses, Sunday afternoon, December 16, in the University Infirmary to make plans for the 1935 course. Representing the Florida Medical Association were the following: Dr. T. Z. Cason of Jacksonville, Chairman of the Committee; Dr. G. C. Tillman, University physician, Gainesville; and Dr. W. H. Spires of Orlando. Dr. G. H. Edwards of Orlando was in Gainesville and was asked to sit in at the meeting.

The committee decided to hold the third short course at the University in June, probably during the week of June 24 to 29. The course will be under the direction of the State Medical Association and General Extension Division of the University. The auditorium and class rooms of the P. K. Yonge Laboratory School building on the campus will be used for lectures and demonstration laboratories.

The topics chosen by the committee, on which prominent men from all over the country will be invited to lecture during the course, are as follows: Pediatrics, Obstetrics, Gynecology, Medicine, Orthopedic Surgery, Venereal Diseases, and Surgery. Definite schedule for the course will be announced to the doctors of the state as soon as the Committee is able to make final arrangements with all of the lecturers. Great care is being exercised to secure the best lecturers and instructors available.

At the meeting, a final report on the second short course, which was held at the University June 25 to 30, 1934, was submitted. The statistics for that course as submitted are as follows:

Total registrations	111
Total number of men	110
Total number of women	1
Total number of instructors registered	7
Total number of practicing physicians registered	104
Total number of states represented	6
Total number of cities represented	53

State	Cities	Representatives
North Carolina	1	1
Pennsylvania	1	5
Tennessee	1	2
Louisiana	1	1
Arkansas	1	1
Florida	53	101
Counties of Florida represented		27

1934 MEMBERSHIP

In this issue will be found the names of members of the Florida Medical Association whose annual dues to the Association have been paid for the year 1934. This official roster of our membership, which appears annually in the February Journal, has been used as a guide to a physician's professional standing or connection with organized medicine.

When a doctor fails to pay dues his name must necessarily be omitted from this membership roster. This is again called to the attention of those of our members who consider themselves officially connected with the organization but who have been negligent in paying their annual dues through the secretary of their county society.

1934 was a banner year insofar as collection of dues was concerned. Twenty-three societies reported 100% of membership dues paid. The societies on the honor roll for last year are: Alachua, Columbia, Dade, Hillsboro, Lee, Leon-Gadsden-Liberty-Wakulla-Jefferson, Madison, Manatee, Marion, Monroe, Orange, Palm Beach, Pasco-Hernando-Citrus, Pinellas, Putnam, St. Johns, St. Lucie-Okeechobee-Indian River-Martin, Sarasota, Seminole, Sumter, Taylor, Volusia, and Walton-Okaloosa.

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CALENDAR YEAR 1934

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337 Lincoln Road.....Miami Beach
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307 Ingraham Bldg.....Miami
Manson, Plumer J.,
277 N. E. 82nd St.....Miami
Martin, M. C.,
548 W. Flagler St.....Miami
Maxwell, E. B.,
610 Huntington Bldg.....Miami
Medlin, Willard B.,
502 Security Bldg.....Miami
Mentzger, Claude,
2701 Biscayne Blvd. Miami
Milton, J. D.,
905 Huntington Bldg.....Miami
Moore, T. E.,
Huntington Bldg. Miami
Morrow, Frank R.,
305 Huntington Bldg.....Miami
Moseley, R. Sam,
Sun Ray Park Hotel.....Miami
Newell, C. E.,
21 S. W. 12th Ave.....Miami
Nichol, E. Sterling,
305 Huntington Bldg.....Miami
Nichols, Frank O.,
37 N. W. 1st St.....Miami
Norton, Richard C.,
Battle Creek Sanitarium,
Miami Springs
O'Quinn, Leon H.....Hialeah
Otto, T. O.,
704 Huntington Bldg.....Miami
Owens, Duncan,
337 Lincoln Road.....Miami Beach
Palmer, Bascom H.,
502 Huntington Bldg.....Miami
Panettiere, Cayetano,
Box 227 Miami Beach
Paulk, George A.,
202 Venetian Bldg.....Miami
Payton, Frazier J.,
Allison Hospital Miami Beach
Pearson, Homer L.,
1108 Huntington Bldg.....Miami
Pearson, John R.,
602 Olympia Bldg.....Miami
Pearson, Nelson T.,
1109 Huntington Bldg.....Miami
Pearson, Rufus J.,
Huntington Bldg.....Miami
Pepper, Max,
719 Seybold Bldg.....Miami
Perdue, Jean,
1213 Lincoln Road....Miami Beach
Perry, C. Larimore,
509 Huntington Bldg.....Miami
Peters, Edgar,
506 Olympia Bldg.....Miami
Phillips, Kenneth,
610 Huntington Bldg.....Miami
Preston, E.,
St. Francis Hospital...Miami Beach
Quillian, Warren,
Coral Gables Clinic....Coral Gables
Raap, Gerard,
908 Huntington Bldg.....Miami
Reiss, George L.,
307 National Blvd.,
Long Beach, N. Y.
Rentz, L. S. Coconut Grove
Rentz, William C.,
3532 N. W. 17th Ave.....Miami
Repass, Robert E.,
337 Lincoln Road.....Miami Beach
Richardson, John R.,
Lincoln Road.....Miami Beach
Rinaman, James,
6043 N. E. 2nd Ave.....Miami
Roberts, S. J.,
46 N. E. 5th St.....Miami
Roche, Charles F.,
Box 483.....Miami Beach
Rogers, Hunter Beall,
27 N. W. 12th Ave.....Miami
Ryan, Harold A.,
Aladdin Medical Arts Bldg.,
Miami Beach
Sams, Wiley M.,
312 Ingraham Bldg.....Miami
Sayles, Charles F.,
311 N. W. Third St.....Miami
Seeds, J. B.,
544 W. Flagler St.....Miami
Shaw, E. Clay,
702 Huntington Bldg.....Miami
Shisler, J. W.,
218 Shoreland Bldg.....Miami
Silverman, Harry Z.,
760 Collins Ave.....Miami Beach
Sinclair, J. A. B.,
275 N. E. 23rd St.....Miami
Skaggs, P. T.,
510 First Natl. Bk. Bldg.....Miami
Smith, C. Kirby,
210 E. Flagler St.....Miami
Smith, J. A. Homestead
Smith, J. W.,
1661 W. Flagler St.....Miami
Smith, Marvin,
405 Huntington Bldg.....Miami
Snyder, John W.,
402 Huntington Bldg.....Miami
Stewart, J. S.,
1105 Huntington Bldg.....Miami
Stuart, J. D.,
227 N. E. 5th St.....Miami
Tallman, Maurice H.,
1401 Huntington Bldg.....Miami
Thomas, Edwin C.,
46 N. E. 5th St. Miami
Thomas, Kelly C.,
318 N. W. 1st St.....Miami
Thomas, Merrick D.,
211 Sixth St.....Miami Beach
Thorne, James I.,
Hotel Europe.....Athens, Greece
Threlkeld, Major Edgar,
Congress Bldg.....Miami
Tower, John B.,
32 N. Krome Ave.....Homestead
Tumlin, Corbett E.,
Ingraham Bldg.....Miami
Turner, John C.,
Tatum Bldg.....Miami
Vinson, Willie J.,
400 Ingraham Bldg.....Miami
Walker, Harrison A.,
704 Lincoln Road.....Miami Beach
Walters, Arthur L.,
337 Lincoln Road.....Miami Beach
Watters, W. H.,
Boston-Miami Clinic, Coconut Grove
Weiland, Arthur H.,
227 Aragon Ave.....Coral Gables
Weinkle, Barney,
302 Huntington Bldg.....Miami
Welch, P. B.,
Huntington Bldg.....Miami
Westermann, Julius T.,
Box 1542, Buena Vista Station,
Miami
White, D. Ward,
347 Lincoln Road.....Miami Beach
Whitten, Benj. L.,
Box 505 Miami
Wilson, M. C.,
809 Huntington Bldg.....Miami
Withers, G. H.,
Aladdin Med. Arts Bldg.,
Miami Beach
Wood, Arthur W.,
401 Security Bldg.....Miami
Woodard, Robert C.,
Jackson Memorial Hospital..Miami
Wright, Sheffel,
315 Ingraham Bldg.....Miami
Youmans, Corren P.,
Veterans Hospital...St. Petersburg
Youmans, I. C.,
653 S. E. 2nd St.....Miami

DE SOTO-HARDEE-HIGHLANDS COUNTY MEDICAL SOCIETY

Highsmith, G. F.,
President Arcadia
Weems, Howard V., Vice-President,
22 Oak Street.....Sebring
Martin, Leldon W.,
Sec'y-Treasurer Sebring
Alexander, Morris J.....Zolpho Springs
Aurin, E. C. Ft. Ogden
Bevis, Henry P.....Arcadia
Brewster, Guy O. Sebring
Chandler, Isaac W.,
First Trust Bldg.....Avon Park
Kayton, M. C. Wauchula
Kirkpatrick, Charles H.,
Box 454.....Arcadia
McKnight, George S.,
Jacaranda Arcade.....Avon Park
McSwain, Gordon H.....Arcadia
Peacock, W. H. Wauchula
Poucher, Allen A.....Wauchula
Simmons, John A.....Arcadia
Spears, Ben D.....Wauchula
Touchton, W. C.....Avon Park

DUVAL COUNTY MEDICAL SOCIETY

Croft, Theo G., President,
St. James Bldg.....Jacksonville
Manning, William S., Vice-President,
310 Greenleaf Bldg.....Jacksonville
Woolsey, Bertram F., Secretary,
320 St. James Bldg.....Jacksonville
Hayes, J. W., Treasurer,
309 Professional Bldg., Jacksonville
Adams, George E.,
2017 Main St.....Jacksonville
Alford, Neil,
St. James Bldg.....Jacksonville
Arms, B. L.,
Box 353 Farmington, Maine
Baker, R. M.,
Professional Bldg.....Jacksonville
*Barfield, Frederick G.,
St. James Bldg.....Jacksonville
Baumgartner, Carl J.,
406 Masonic Bldg.....Jacksonville
Bayless, W. C.,
202 St. James Bldg....Jacksonville
Beckman, George E.,
Professional Bldg.....Jacksonville
Black, J. B.,
St. James Bldg.....Jacksonville
Blackmar, Ray Wellborn,
320 St. James Bldg....Jacksonville
Boone, James L.,
500 Professional Bldg, Jacksonville
Borland, J. L.,
2033 Riverside Ave.....Jacksonville
Bransford, L. E.,
Professional Bldg.....Jacksonville
Brillhart, H. L.,
Graham Bldg.....Jacksonville
Brink, Fritz A.,
Box 210 Jacksonville
Brinson, P. A.....Baldwin
Brinson, W. D.....Baldwin
Broadbent, Oliver P.,
454 St. James Bldg.....Jacksonville
Brown, Alan DeWitt,
417 St. James Bldg....Jacksonville
Bryant, James M.,
303 Medical Arts Bldg., Jacksonville
Buckman, Thomas E.,
1022 Park St.....Jacksonville
Carefoot, E. I.,
Professional Bldg.....Jacksonville
Cason, Turner Z.,
2033 Riverside Ave.....Jacksonville
Chapman, Benjamin A.,
2151 Pearl St.....Jacksonville
Chilli, Joseph L.,
St. James Bldg.....Jacksonville
Collins, C. C.,
1855 Laura St.....Jacksonville
Copeland, Silas M.,
203 St. James Bldg.....Jacksonville
Copp, F. A.,
458 St. James Bldg....Jacksonville
Counts, H. W.,
312 Peninsular Life Bldg,
Jacksonville

*Deceased.
†Honorary Member.

Croft, George W.,
St. James Bldg.....Jacksonville
Cunningham, Lester W.,
St. James Bldg.....Jacksonville
Day, Gaston,
310 W. Church St.....Jacksonville
Dean, Russell,
St. James Bldg.....Jacksonville
Drew, Horace R.,
St. James Bldg.....Jacksonville
Driskell, Simon E.,
St. James Bldg.....Jacksonville
Dyrenforth, Lucien Y.,
Box 2098, W. Bay Annex,
Jacksonville
Eaton, Paul,
State Board of Health..Jacksonville
Erwin, Stanley,
1001 Lynch Bldg.....Jacksonville
Field, Thomas S.,
712 Laura St.....Jacksonville
Fort, Frank L.,
312 Medical Arts Bldg..Jacksonville
Gammon, Julian E.,
700 Professional Bldg..Jacksonville
Goodale, Banks H.,
St. James Bldg.....Jacksonville
Gorman, John M.,
424 St. James Bldg....Jacksonville
Greene, Ralph,
Medical Arts Bldg.....Jacksonville
Gurganious, Allen P.,
Green Cove Springs
Hanson, Henry,
State Board of Health..Jacksonville
Harrell, D. E.,
St. James Bldg.....Jacksonville
Harrell, O. E.,
St. James Bldg.....Jacksonville
Harris, Herrman H.,
608 Greenleaf Bldg.....Jacksonville
Harris, W. G.,
St. James Bldg.....Jacksonville
Hartman, James H.,
546 Lomax St.....Jacksonville
Henley, Charles F.,
2151 Pearl St.....Jacksonville
Henson, Graham E.,
201 St. James Bldg.....Jacksonville
Holden, Gerry R.,
Medical Arts Bldg.....Jacksonville
Holloway, Luther W.,
359 St. James Bldg....Jacksonville
Horne, Hendley F.,
325 W. Duval St.....Jacksonville
Hughes, V. A.,
302 St. James Bldg....Jacksonville
Humphreys, David G.....Fernandina
Ira, Gordon H.,
452 St. James Bldg.....Jacksonville
Ives, Harold A.,
711 Roselle.....Jacksonville
Jelks, Edward,
Riverside Hospital.....Jacksonville
†Jennings, C. L.,
Medical Arts Bldg.....Jacksonville
Johnston, Crowell W.,
355 St. James Bldg.....Jacksonville
Keisling, Frederick C.,
315 Professional Bldg., Jacksonville
Killinger, Raymond R.,
St. James Bldg.....Jacksonville
Kirby-Smith, Joseph L.,
1115 Greenleaf Bldg....Jacksonville
Kirk, William W.,
608 Greenleaf Bldg.....Jacksonville
Knauer, W. Jerome,
Buckman Bldg.....Jacksonville
Laffitte, L. Sydnor,
Medical Arts Bldg.....Jacksonville
Lamb, Robert J.,
248 Hendricks Ave., So. Jacksonville
Limbaugh, Louie M.,
458 St. James Bldg....Jacksonville
Lipscomb, T. H.,
St. Luke's Hospital....Jacksonville
McDaniel, R. L.,
1855 Laura St.....Jacksonville
McEuen, H. Bernard,
320 Professional Bldg...Jacksonville
McGinnis, Robert H.,
2063 Oak St.....Jacksonville
McIver, Robert B.,
St. James Bldg.....Jacksonville
McKenzie, Albert C.,
St. James Bldg.....Jacksonville
Mabry, C. B.,
202 Medical Arts Bldg..Jacksonville
Manhoff, Ben,
712 Laura St.....Jacksonville
Martin, P. H.,
Professional Bldg.....Jacksonville
May, Robert D.,
302 Professional Bldg..Jacksonville
Mitchell, George M.,
712 Laura St.....Jacksonville
Mitchell, John H.,
300 Professional Bldg...Jacksonville
Moe, Leonard N.,
212 St. James Bldg....Jacksonville
Morris, Kenneth A.,
237 W. Duval St.....Jacksonville
Morris, S. A.,
237 W. Duval St.....Jacksonville
Norris, Samuel R.,
Medical Arts Bldg.....Jacksonville
Norwood, J. K.,
211 St. James Bldg.....Jacksonville
Oberdorfer, Aaron Z.,
409 St. James Bldg.....Jacksonville
Oetjen, G. F.,
211 E. Forsyth.....Jacksonville
Owens, J. H.,
1855 Laura St.....Jacksonville
Palmer, Thomas M.,
2063 Oak St.....Jacksonville
Parramore, James B.,
401 St. James Bldg.....Jacksonville
Pasco, J. D.,
Medical Arts Bldg.....Jacksonville
Peterson, C. A.,
St. James Bldg. Jacksonville
Peyton, Harry A.,
2033 Riverside Ave.....Jacksonville
Porter, H. W.,
340 St. James Bldg.....Jacksonville
Quasser, Adolph B.,
404 Medical Arts Bldg..Jacksonville
Ramage, Raymond B.,
219 Professional Bldg...Jacksonville
Randolph, J. H.,
St. James Bldg.....Jacksonville
Richards, Ferdinand,
1022 Park Street.....Jacksonville
Richardson, George W.,
343 St. James Bldg....Jacksonville
Richardson, Shaler,
111 W. Adams Street..Jacksonville
Roberts, Earl.....Jacksonville Beach
Rogers, W. W.,
Professional Bldg.....Jacksonville
Rollins, Clarence D.,
2104 Riverside Ave.....Jacksonville
Ross, William E.,
St. James Bldg.....Jacksonville
Royce, Clayton E.,
Box 2098, W. Bay Annex,
Jacksonville
Safer, Jacob V.,
452 St. James Bldg.....Jacksonville
Sanderson, Raymond,
216 Professional Bldg...Jacksonville
Sandusky, C. M.,
28 W. Monroe St.....Jacksonville
Schnauss, William R.,
312 Hildebrandt Bldg...Jacksonville
Schneider, David,
Greenleaf Bldg.....Jacksonville
Sellers, E. T.,
412 St. James Bldg.....Jacksonville
Sengstak, Ernst P. E.....Mandarin
Shaw, William M.,
St. James Bldg.....Jacksonville
Simpson, J. Knox,
712 Laura St.....Jacksonville
Stinson, W. M.,
1611 Aberdeen St.....Jacksonville
Stollenwerck, A. D.,
2005 Oak St.....Jacksonville
Swift, Edwin C.,
1022 Park St.....Jacksonville
Taylor, H. Marshall,
111 W. Adams St.....Jacksonville
Teeter, Edmund H.,
305 St. James Bldg.....Jacksonville
Thompson, David C.,
2579 Herschell St.....Jacksonville
Thompson, T. C.,
318 Hildebrandt Bldg., Jacksonville
Tyler, Lockland V.,
San Marco Square, So. Jacksonville
Upchurch, Noble A.,
City Board of Health..Jacksonville
Van Schaick, Harold D.,
210 St. James Bldg....Jacksonville
Veal, Ernest W.,
128 St. Johns Ave...So. Jacksonville
Waas, Frederick J.,
Professional Bldg.....Jacksonville
Washburn, Clayton D.,
St. James Bldg.....Jacksonville
Wilcox, Clarence R.,
712 Laura St.....Jacksonville
Wilkinson, Albert H.,
313 Professional Bldg., Jacksonville
Wilson, A. K.,
St. James Bldg.....Jacksonville
Wynn, Robert S.,
305 Consolidated Bldg..Jacksonville

ESCAMBIA COUNTY MEDICAL SOCIETY

Payne, W. C., President,
Blount Bldg.....Pensacola
Thames, Rufus, Vice-President, Milton
Hoffman, James M., Sec'y-Treasurer,
6 W. Chase St.....Pensacola
Ames, Allen M.,
206 Blount Bldg.....Pensacola
Anderson, Warren E.,
511 American Natl. Bk. Bldg.,
Pensacola
Bell, John D.,
505 Blount Bldg.....Pensacola
Blackshear, T. E.,
406 American Natl. Bk. Bldg.,
Pensacola
Born, Charles C.,
513 Blount Bldg.....Pensacola
Bryans, H. L.,
21½ E. Wright St.....Pensacola
Daniels, J. P.,
313 Brent Bldg.....Pensacola
Dodson, M. W.,
Box 57.....Alaflora, Ala.
Fellows, J. H.,
Brent Bldg. Pensacola
Fisher, Luther C., Jr.,
21½ E. Wright St.....Pensacola
Gachet, Necy L. Century
Haisfield, Abram R.,
311 Blount Bldg.....Pensacola
Haisfield, H. B.,
311 Blount Bldg.....Pensacola
Heinberg, Charles J.....Pensacola
Holley, John C. Milton
Kennedy, S. G.,
511 American Natl. Bk. Bldg.,
Pensacola
Lischkoff, M. A.,
Blount Bldg.....Pensacola
McGuire, J. J.,
Pensacola Hospital.....Pensacola
McLane, J. N.,
204 W. Brainard St.....Pensacola
Mock, A. E.,
314 Blount Bldg.....Pensacola
Nobles, R. G.,
Blount Bldg.....Pensacola
Nobles, V. R.,
Blount Bldg.....Pensacola
Nobles, W. D.....Pensacola
Pierpont, Juriah H.,
511 American Bk. Bldg., Pensacola
Quina, M. E.....Pensacola
Renshaw, F. G.,
104 S. Palafox.....Pensacola
†Simpson, Horace L.,
20 W. Belmont.....Pensacola
Sullivay, Rosa L.,
1016 W. Chase St.....Pensacola
Turberville, J. I.....Century
Turberville, John S.....Century
Turner, John B.,
Bagdad (Santa Rosa County)
Webb, Carol C.,
303 Blount Bldg.....Pensacola
White, Alvyn W.,
Box 1345 Pensacola

HILLSBORO COUNTY MEDICAL SOCIETY

Gilmer, Eugene S., President,
416 Citizens Bank Bldg.....Tampa
Bottari, Giulio C., Vice-President,
1425½ E. Broadway.....Tampa
Helms, John S., Jr., Sec'y-Treasurer,
Box 1439 Tampa
Adamson, William P.,
610 Citizens Bank Bldg.....Tampa
Allen, Bundy,
302 Citizens Bank Bldg.....Tampa
Alsobrook, John W.,
120 N. Collins St.....Plant City
Andrews, Chadbourne A.,
715 Citizens Bank Bldg.....Tampa
Austis, Edgar.....Plant City
Barker, Frank T.,
302 Krause Bldg.....Tampa
Bartlett, Charles Wm., Jr.,
310 First Natl. Bk. Bldg.....Tampa
Bergman, Sam,
2208 N. Boulevard Ave.....Tampa
Beyer, A. R.,
Box 527 Tampa
Bidwell, Alfred M.,
401 First Natl. Bk. Bldg.....Tampa
Bitzer, Emory W.,
815 Citizens Bank Bldg.....Tampa
Black, Robert C.,
101 San Ever St.....Plant City

*Deceased.
†Honorary Member.

Blackmon, H. J.,
Citizens Bank Bldg.....Tampa
Blake, W. C.,
412 Citizens Bank Bldg.....Tampa
Boling, John R.,
1207 First Natl. Bk. Bldg....Tampa
Brown, G. W., Jr.,
706 Franklin St.....Tampa
Brown, Harold O.,
215 Madison St.....Tampa
Butchart, T. R.,
804 Grand Central Ave.....Tampa
Carlton, Leland F.,
805 Citizens Bank Bldg.....Tampa
Carter, E. F.,
1903 Grand Central Ave.....Tampa
Chandler, J. C.,
410 Citrus Exchange Bldg...Tampa
Cook, George L.,
906 So. Rome Ave.....Tampa
Cook, H. M.,
107 Parker St.....Tampa
Costa, Frank J.,
Centro Austuriano Hosp.....Tampa
Cowart, James T.,
906 South Rome.....Tampa
Crum, James W.,
413 Central Office Bldg.....Tampa
Davis, William J.,
516½ Franklin St.....Tampa
Dickinson, Joshua C.,
302 Citizens Bank Bldg.....Tampa
Dominguez, J. A.,
Box 5745 Tampa
Draper, Arthur D.,
5607 Florida Ave. Tampa
Duke, Roncie R.,
708 Citizens Bank Bldg.....Tampa
Duncan, William P.,
802 Tampa Theatre Bldg.....Tampa
Dyer, Walter H.,
1801½ 22nd St. Tampa
Efird, Lester J.,
1019 W. Platt St.....Tampa
Ely, R. A.,
404½ Zack St.....Tampa
Estes, J. L.,
815 First Natl. Bk. Bldg.....Tampa
Etheredge, S. H.,
706 Franklin St.....Tampa
Evans, Harry C.,
215 Madison St.....Tampa
Faver, Henry M.,
402 Citrus Exchange Bldg....Tampa
Ferrante, G. C.,
406 Citrus Exch. Bldg.....Tampa
Fluker, Carl B.,
3002 San Nicholas.....Tampa
Forbes, Sherman B.,
409 Citizens Bank Bldg.....Tampa
Garcia, Parsons M.,
Box 7224 West Tampa
Gilbert, Elsie,
6508 Central Ave.....Tampa
Grable, James S.,
822 Citizens Bank Bldg.....Tampa
Grantham, James M.,
442 Lafayette Arcade.....Tampa
Guerra, Julio J.,
First Natl. Bk. Bldg.....Tampa
Gyland, Stephen P.,
215 Madison St.....Tampa
Halton, Jack,
619 Citizens Bank Bldg.....Tampa
Hardy, George E. W.,
818 First Natl. Bk. Bldg.....Tampa
Henderson, Robert P.,
612 Citizens Bank Bldg.....Tampa
Higgins, Allen F.,
814 So. Orleans Ave.....Tampa
Holloway, E. W.,
1801½ 21st St.....Tampa
Hopkins, Clack D.,
1818 Hillsboro Ave.....Tampa
Jefferson, Rollin,
818 First Natl. Bk. Bldg....Tampa
Jensen, Henry J.,
7303 Nebraska Ave.....Tampa
Knauf, A. R.,
706 Franklin St.....Tampa
Knight, John C.,
121 N. Collins St.....Plant City
Lake, Esley T.,
Box 8968 Tampa
Lancaster, William J.,
Box 3010 Tampa
Lowry, Blackburn W.,
408 Citrus Exchange Bldg...Tampa
McClosky, B. Martin,
1801½ 22nd St.....Tampa
McEachern, J. R.,
Box 2214 Tampa
McRae, E. H.,
108 Memorial Highway.....Tampa
Maguire, Thomas C.,
104 S. Collins St.....Plant City
Maner, George R.,
5111 Central Ave.....Tampa
Martin, Douglas D.,
906 So. Rome Ave.....Tampa
Martorell, Abelardo,
310 First Natl. Bk. Bldg.....Tampa
Meighen, Douglas G.,
Citrus Exchange Bldg.....Tampa
Metzger, Frank C.,
916 Citizens Bank Bldg.....Tampa
Mills, Herbert R.,
706 Franklin St.....Tampa
Mills, John H.,
910 E. Columbus Drive.....Tampa
Minardi, Joseph A.,
2203½ Seventh Ave.....Tampa
Mitchell, L. B.,
Box 1020 Tampa
Mols, Edith P.,
Citizens Bank Bldg.....Tampa
Moore, John T.,
317 Tribune Bldg.....Tampa
Myers, Wade C.,
302 Schulte-United Bldg.....Tampa
Nelson, Robert G.,
712 Citizens Bank Bldg.....Tampa
†Oppenheimer, Louis S.,
108 Crescent Place.....Tampa
Ortega, Rafael,
Box 5513, Ybor Station.....Tampa
Pate, Julien C.,
1107 First Natl. Bk. Bldg....Tampa
Patterson, William,
312 Citrus Exchange Bldg...Tampa
Pearson, R. J.,
Route 1, Box 198.....Tampa
Pease, Charles W.,
State Board of Health.....Tampa
Porro, Gustavo F.,
1915½ 14th St. Tampa
Portocarrero, N. A.,
1915½ 14th St.....Tampa
Rankin, Grover C.,
Box 1313 Tampa
Rector, Lee T.,
Citizens Bank Bldg.....Tampa
Rowlett, William M.,
Box 786 Tampa
Rudisill, C. A.,
706 Franklin St.....Tampa
Saxton, J. J.,
315 Citrus Exchange Bldg...Tampa
Shaver, E. F.,
1801½ 22nd St.....Tampa
Smith, H. Mason,
903 Tampa Theatre Bldg....Tampa
Smoak, Edward,
315 Citizens Bank Bldg.....Tampa
Snow, H. O.,
1903 Grand Central Ave.....Tampa
Spengler, Nathaniel L.,
903 Tampa Theatre Bldg.....Tampa
Spoto, Joseph S.,
1829½ E. Broadway.....Tampa
Stone, Alvord L.,
102 E. Hillsboro Ave.....Tampa
Stringer, Sheldon,
Box 105.....Tampa
Taylor, Joseph W.,
706 Franklin St.....Tampa
Torbett, R. S.,
409 First Natl. Bk. Bldg.....Tampa
Truelsen, Thomas,
706 Franklin St.....Tampa
Vinson, J. C.,
Box 724 Tampa
Weekley, A. S.,
401 City Bank Bldg.....Tampa
Winton, M. R.,
402 Citrus Exchange Bldg...Tampa

JACKSON COUNTY MEDICAL SOCIETY

Miller, Redden L., President,
Box 186 Graceville
Pierce, J. Lewis, Sec'y-Treasurer,
Marianna
Baltzell, N. A.....Marianna
Box, C. C. Graceville
Burns, M. Q.....Blountstown
Dowling, J. B.....Alliance
McKinnon, Daniel A.....Marianna
Price, C. J.....Alford
Ryals, C. H.,
R. F. D. No. 1.....Grand Ridge
Vandiviere, S. P.,
Camp P 54.....Brewton, Ala.

LAKE COUNTY MEDICAL SOCIETY

Wood, Will L., President...Mount Dora
Williams, Rabun H., Vice-President,
Theatre Bldg.....Eustis
Ashton, W. Lee, Sec'y-Treasurer,
Umatilla
Bowen, Louis R.,
Box 905.....Eustis
Colley, Sanford C.....Tavares
Coleman, E. M.....Groveland
Conklin, Raymond C.,
141 W. 6th Ave.....Mount Dora
DeVane, W. G. Groveland
Fenn, Harry T.....Mount Dora
Hannum, M. M.....Eustis
Hawkins, A. S.,
779 Montrose St.....Clermont
Holland, Howard G.,
202 State Bank Bldg.....Leesburg
Izlar, A. L.....Clermont
Morrison, Harry K.,
601 W. Magnolia.....Leesburg
Oetjen, Leroy H.....Leesburg
Toy, Samuel H.....Umatilla
Tyre, C. McK.....Eustis

LEE COUNTY MEDICAL SOCIETY

Harrison, Warren A., President,
Pythian Bldg.....Ft. Myers
Bostelman, Ernest, Vice-President,
201 Pythian Bldg.....Ft. Myers
Newton, Robley D., Sec'y-Treasurer,
5-6 Earnhardt Bldg.....Ft. Myers
Grace, William H.,
15 Earnhardt Bldg.....Ft. Myers
Johnson, M. F.....Ft. Myers
Jones, H. Quillian,
18-20 Leon Bldg.....Ft. Myers
Longbrake, Guy A.,
308 Second St.....Ft. Myers
Merrick, C. Gordon,
26 Leon Bldg.....Ft. Myers
Whisnant, Baker,
3 Leon Bldg.....Ft. Myers

LEON-GADSDEN-LIBERTY-WAKULLA-JEFFERSON COUNTY MEDICAL SOCIETY

Pound, J. H., President..Chattahoochee
Johnston, John K., Vice-President,
Exchange Bank Bldg...Tallahassee
Kendrick, Odis G., Sec'y-Treasurer,
Tallahassee
Barnes, Benjamin F.....River Junction
Beggs, John M.,
Fla. State Hospital..Chattahoochee
Brevard, E. M.,
Lively Corner.....Tallahassee
Brinson, John B.,
Dogwood St.....Monticello
Cobb, Alva T., Jr.,
Fla. State Prison.....Raiford
Davis, Julius C.,
203 Masonic Bldg.....Quincy
Dozier, L. L.....Tallahassee
Gardner, O. W.....Greensboro
Glover, George B.....Monticello
Godard, Robert F.,
Key Building.....Quincy
Graves, L. J.,
Box 623.....Tallahassee
Harper, J. Andrew.....Crawfordville
McClure, Herbert A.,
State Board of Health Bldg..
Tallahassee
Massey, William W.,
Davidson Bldg. Quincy
Moor, F. Clifton,
Telephone Bldg.....Tallahassee
Murrow, J. S.....Apalachicola
Palmer, Henry E.,
408 S. Adams St.....Tallahassee
Rhodes, Bricey M.....Tallahassee
Salley, S. Marion.....Tallahassee
Walker, William H.....Lamont
Wilensky, M. C.,
Fla. State Hospital..Chattahoochee
Wilhoit, Sterling E.....Quincy
Wilkinson, B. A.,
Telephone Bldg.....Tallahassee
Williams, J. F.....Monticello
Williams, John L.....Tallahassee

MADISON COUNTY MEDICAL SOCIETY

Davis, George O.....Madison
Long, Eustace.....Madison

MANATEE COUNTY MEDICAL SOCIETY

English, A. Q., President.....Palmetto
Larrabee, Charles W., Vice-President,
Larrabee Hospital.....Bradenton
Sugg, William D., Sec'y-Treasurer,
Bradenton Bank Bldg....Bradenton
Blake, Lowrie W.....Bradenton
Floyd, A. J.....Palmetto

*Deceased.
†Honorary Member.

Gates, Hubbard,
Box 245.....Bradenton
Harrison, M. M.....Bradenton
Hollingsworth, Samuel G.,
451 Twelfth St.....Bradenton
Lancaster, B. M. Manatee
McDuffee, Toliver M.....Manatee
Mason, John F. Bradenton
Stebbins, A. L.....Punta Gorda

MARION COUNTY MEDICAL SOCIETY

Chalker, James L., President,
719 E. Ocklawaha Ave.....Ocala
Brown, Andrew G., Vice-President,
Dunnellon
Cumming, Richard C., Sec'y-Treasurer,
Commercial Bank Bldg.....Ocala
Cammack, K. R.....Gulf Hammock
Curry, J. F.....Dunnellon
Dozier, Henry C.,
9 N. Magnolia St.....Ocala
Ferguson, R. D.,
Box 802.....Ocala
Freeman, Albert H.,
Holder Block.....Ocala
Gatrell, Henry Fairfield
†Hood, J. W.....Ocala
Lindner, E. G.....Ocala
Lisk, Percy F.....Ft. McCoy
Martin, Irl E. Ocklawaha
Mathews, A. L.,
Box 190 Sarasota
Moore, J. N.,
210 Professional Bldg.....Ocala
Peek, Eugene G.,
Commercial Bank & Trust Bldg.,
Ocala
Russell, Ralph E.....Ocala
Slaughter, T. K.....Oxford
Strange, J. L.....McIntosh
Strickland, Edgar E.....Citra
Wallis, Thomas H.,
104 S. Magnolia.....Ocala
Watt, Harry F.,
Box 146.....Ocala

MONROE COUNTY MEDICAL SOCIETY

Galey, Harry C.,
532 Fleming St.....Key West
Warren, William R., Sec'y-Treasurer,
511 Eaton St.....Key West
Fina, Ricardo.....Key West

ORANGE COUNTY MEDICAL SOCIETY

Chappell, John R., President,
Box 1370.....Orlando
Rivers, T. M., Vice-President,
Kissimmee
Pines, John A., Secretary,
106 E. Central Ave.....Orlando
Day, Horace A., Treasurer,
209 Exchange Bldg.....Orlando
Andrews, Laurin L.,
Box 1100.....Orlando
Andrews, M. M.,
Box 1817.....Orlando
Beardall, Harold M.,
147 E. Church St.....Orlando
Brinson, Haynes Kissimmee
Buff, Julian H.,
49 N. Orange Ave.....Orlando
Burks, B. Auxford,
108 E. Park Avenue...Winter Park
Butler, Paul T.,
23 Autrey Arcade.....Orlando
Chiles, J. H.,
Box 943.....Orlando
Christ, Calvin D.,
Box 1137 Orlando
Collins, Charles J.,
209 Exchange Bldg.....Orlando
Dodds, William H.,
11th St. & Pa. Ave.....St. Cloud
*Edwards, Gaston H.,
106 E. Central Ave.....Orlando
Folsom, Spencer A.,
11 Lucerne Circle.....Orlando
Gardner, J. F. Winter Park
Geiger, Hugh St. C.,
24½ Broadway.....Kissimmee
Gray, Frank D.,
311 Exchange Bldg.....Orlando
Gwynn, Humphrey W.,
Clinic Bldg.....Orlando
Harms, F. H.,
40 N. Orange St.....Orlando
Hart, Ruth S. Winter Park
Hoffman, Carl D.,
25 Autrey Arcade.....Orlando
Hotard, Roland F.,
226 E. Park Ave.....Winter Park
Ingram, L. C.,
Box 1711 Orlando
†Johnston, Colonel Geo. C.,
Box 272 Orlando
Johnston, Hewitt,
Box 2002 Orlando
Lawrence, E. J. Winter Garden
Lawson, Ben Hill.....Winter Garden
Lewis, P. M.,
Box 346 Orlando
Lynn, C. W.,
Fla. Sanitarium.....Orlando
McBride, Thomas E.....Apopka
McEwan, Duncan T.,
106 E. Central Ave.....Orlando
McEwan, John S.,
106 E. Central Ave.....Orlando
Mallory, Meredith,
Box 1011.....Orlando
Miles, W. G.,
1305 Glenwood Ave.,
Greensboro, N. C.
Morton, B. Rosalie S.....Winter Park
Neal, Thomas A.,
Box 321 Orlando
Oertel, H. B.,
32 E. Concord Ave.....Orlando
Orr, Louis McD.,
311 Exchange Bldg.....Orlando
Osincup, Gilbert S.,
300 E. Colonial Drive.....Orlando
Page, W. Grady,
State Bank Bldg.....Orlando
†Person, W. C.,
258 S. Main St.....Orlando
Redding, John L.,
126 S. Orange St.....Orlando
Shoemaker, Samuel A.,
30 E. Church St.....Orlando
Sinclair, W. E.,
Clinic Bldg.....Orlando
Spiers, William H.,
Box 1712 Orlando
Sutter, Leroy M.,
714 Woodward Ave.....Orlando
Taylor, B. E.,
Florida Sanitarium.....Orlando
Weed, Walter A.,
2nd Floor, Exch. Bldg.....Orlando
White, Roland T.,
211 S. Rosalind Ave.....Orlando
Wood, Robert G.....St. Cloud

PALM BEACH COUNTY MEDICAL SOCIETY

Sayad, William Y., President,
1215 Harvey Bldg...W. Palm Beach
Sory, B. B., Jr., Vice-President,
Harvey Bldg.....W. Palm Beach
Baldwin, R. Henry, Secretary,
1101 Harvey Bldg...W. Palm Beach
Herpel, Frederick K., Treasurer,
Box 1057 W. Palm Beach
Arnold, Wilbur O.,
Box 1735.....W. Palm Beach
Binkley, John F.,
1206 Harvey Bldg...W. Palm Beach
Blair, William M.,
424 Comeau Bldg...W. Palm Beach
Brantley, Grady H.,
Box 336 Lake Worth
Buck, William J.....Belle Glade
Cason, John R.....Delray Beach
Clay, B. S.,
248 Lakewood N. E., W. Palm Beach
Cooley, Roy O.,
Box 1735.....W. Palm Beach
Cram, George E.,
403 Clematis St.....W. Palm Beach
Creel, Charles E.....Pahokee
Davis, K. M.,
Central Arcade.....Delray Beach
Dawson, George M.,
Box 1836.....W. Palm Beach
Denison, Raymond C.,
521 Lake Ave.....Lake Worth
Elarbee, George W. Pahokee
Fleming, S. Ward,
417 Harvey Bldg...W. Palm Beach
Gardner, William H.,
Comeau Bldg.....W. Palm Beach
George, William W.,
1116 Harvey Bldg...W. Palm Beach
Gill, Richard S.,
1114 Florida Ave....W. Palm Beach
Hazen, Olen B.....Pahokee
Heath, Guy W.,
409 Harvey Bldg....W. Palm Beach
Henry, Gordon F.,
305 Citizens Bldg....W. Palm Beach
Jackson, Noah.....Glenville, N. C.
Johnson, Vesey M.,
Good Samaritan Hospital,
W. Palm Beach
King, Graham W., Jr.,
Love Bldg. Delray Beach
Lewis, Gaylord,
Harvey Bldg.....W. Palm Beach
Miller, Alice R.,
418 Fern St.....W. Palm Beach
Netto, Lloyd J.,
415 Comeau Bldg....W. Palm Beach
Nowling, James C.,
309 Harvey Bldg....W. Palm Beach
Papot, Grace E.,
811 Harvey Bldg....W. Palm Beach
Pittman, J. H.,
Box 552 W. Palm Beach
Powell, J. A.,
627 So. Olive.....W. Palm Beach
Randall, Floyd H.....Boca Raton
Rowe, Alva L.....Lake Worth
Rozier, Laughlin McK.,
411 Comeau Bldg...W. Palm Beach
Shackelford, C. W.....W. Palm Beach
Shackelford, W. L.....W. Palm Beach
Sory, James R.....Lake Worth
Stone, Vale D.,
313 Monroe Drive...W. Palm Beach
Van Landingham, William E.,
Citizens Bldg.....W. Palm Beach
Warren, Hobart E.,
Phipps Plaza.....Palm Beach
Webb, Roy,
Box 454 Palm Beach
Weems, Nat. M.....Boynton
Whitman, Frank S.,
512 Comeau Bldg....W. Palm Beach
Wilber, A. B. Palm Beach
Young, Wilburn C.....Canal Point

PASCO-HERNANDO-CITRUS COUNTY MEDICAL SOCIETY

Hudson, P. J. Crystal River
Anderson, Claude, Vice-President,
1400 E. Church St.....Orlando
Harvard, S. C., Vice-President,
Brooksville
Creekmore, George R., Sec'y-Treasurer,
112 N. Main St.....Brooksville
Bourke, John J.....Dade City
Bradshaw, J. T.....San Antonio
Cannon, Augustus B.....Lacoochee
Coogler, A. C.....Brooksville
Dame, George A.,
241 Main St.....Inverness
Dame, Leland H.....Inverness
*Jackson, Thomas F.....Dade City
Jones, W. Wardlaw.....Dade City
Mills, David A.....Zephyrhills
Moon, William B.....Crystal River
Sistrunk, Robert D.....Dade City

PINELLAS COUNTY MEDICAL SOCIETY

Rudolph, Council C., President,
512 Power & Light Bldg.,
St. Petersburg
Lochner, G. M., Vice-President,
406 Power & Light Bldg.,
St. Petersburg
Gable, Nonie Worth, Vice-President,
706 Power & Light Bldg,
St. Petersburg
Feaster, Orion O., Secretary,
St. Anthony's Hospital,
St. Petersburg
McConnell, W. C., Treasurer,
1005 Equitable Bldg., St. Petersburg
†Albaugh, Andrew P....Tarpon Springs
Anderson, Arnold S.,
702 Power & Light Bldg.,
St. Petersburg
Anderson, C. O.,
333 Third St. N.....St. Petersburg
Anderson, J. M.,
333 Third St. N.....St. Petersburg
Anderson, William D.,
Box 53.....Largo
Bieker, Annette M.,
825 Power & Light Bldg.,
St. Petersburg
Black, M. Eldridge,
311 Coachman Bldg.....Clearwater
Burnette, Elmer W.,
First Nat. Bk. Bldg., Tarpon Springs
Burnette, P. C.....Tarpon Springs
Burns, A. B.....Tarpon Springs
Center, R. H.,
Coachman Bldg.....Clearwater
Cooper, J. H.,
First Natl. Bk. Bldg., St. Petersburg
Davis, W. M.,
342 First Ave. N.....St. Petersburg
Dawson, S. A.,
870 Seventh Ave. N., St. Petersburg
Dickerson, Lucien B.,
Williamson Bldg.....Clearwater

*Deceased.
†Honorary Member.

Echard, T. B.,
Fla. Natl. Bk. Bldg., St. Petersburg
Farber, William P.,
807 Power & Light Bldg.,
St. Petersburg
Funk, Neil E.,
702 Power & Light Bldg.,
St. Petersburg
Gable, Linwood M.,
Power & Light Bldg., St. Petersburg
Gable, Nonie Wilson,
Health Department,
175 Fifth St. N.....St. Petersburg
Green, T. H.,
614 Hall Bldg.....St. Petersburg
Griffin, Thomas R.,
Power & Light Bldg., St. Petersburg
Groves, W. H.....Clearwater
Harden, W. W.,
814 First Natl. Bk. Bldg.,
St. Petersburg
Hardenbergh, John A.,
404 Power & Light Bldg.,
St. Petersburg
Hebard, C. E.,
Fla. Natl. Bk. Bldg., St. Petersburg
Heibner, Eugene A.,
Power & Light Bldg., St. Petersburg
Herring, John A.,
350 Third Ave. N....St. Petersburg
Hooper, C. A.,
Glen Eden Hotel, Glen Arbor, Mich.
Horne, Lester W.,
Power & Light Bldg., St. Petersburg
Jennings, Frank S.,
248 Third St. N.....St. Petersburg
Kauffman, Frank E.,
Coachman Bldg.....Clearwater
Knowlton, R. H.,
Power & Light Bldg., St. Petersburg
Lambdin, L.,
Box 1805 St. Petersburg
Langley, Francis H.,
614 Times Bldg.....St. Petersburg
LeBreton, Prescott,
American Legion Hospital,
St. Petersburg
Leith, Richard B.,
201 Snell Bldg.....St. Petersburg
Lustig, Emil,
500 Seventh Ave. N., St. Petersburg
MacCordy, Earl C.,
1335 Ninth St. N.....St. Petersburg
Marr, Norval M.,
812 Power & Light Bldg.,
St. Petersburg
Mease, John A.,
Virginia Avenue.....Dunedin
Melville, Edmond J.,
335 Third Ave. N.....St. Petersburg
Miller, George E.,
411 Third Ave. N.....St. Petersburg
Mills, Alvin L.,
814 First Natl. Bk. Bldg.,
St. Petersburg
Moeller, Maximilian W.,
1077 Fifteenth Ave. N.,
St. Petersburg
Murphy, Ralph D.,
Box 82 St. Petersburg
Nettles, Robbins,
402 Coachman Bldg.....Clearwater
Nickle, Millen A.,
503 Coachman Bldg.....Clearwater
O'Brien, Raymond K.,
105 Fifth Ave. N.....St. Petersburg
†Osgood, G. E.,
2804 Fourth St. S....St. Petersburg
Owen, W. S.,
103 Fifth St. S.....St. Petersburg
†Peabody, J. D.,
456 Third St. N.....St. Petersburg
Post, William G., Jr.,
814 Power & Light Bldg.,
St. Petersburg
Prather, B. T.,
701 Fla. Natl. Bk. Bldg.,
St. Petershurg
*Putnam, Harry L.,
1027 17th Ave. N....St. Petersburg
Quicksall, J. Braden,
221 Taylor Arcade...St. Petersburg
Quicksall, William E.,
222 Taylor Arcade...St. Petersburg
Roope, A. P. Columbus, Ind.
Roush, Franklin W.,
4689 Lakeview Ave., St. Petersburg
Simcox, Lawrence,
201 Third St. N.....St. Petersburg
Solomon, H. D.,
Power & Light Bldg. St. Petersburg
Stevens, Ralph E.,
827 Jungle Ave.....St. Petersburg

*Deceased.
†Honorary Member.

Strickland, Jesse A.,
712 Power & Light Bldg.,
St. Petersburg
Stuart, M. H.,
208 Equitable Bldg., St. Petersburg
Timberlake, Gideon,
6th Floor Times Bldg.,
St. Petersburg
Wade, Hugh W.,
512 Fla. Power Bldg., St. Petersburg
Wells, John S., Jr.,
310 Coachman Bldg.....Clearwater
White, Benj. Lewis,
202 First Natl. Bk. Bldg.,
St. Petersburg
Whitford, Grace R.....Ozona
Williams, Carl A.,
Box 975.....St. Petersburg
Winchester, Harold E.,
Box 448 Dunedin
Wood, Alvin J.,
801 First Natl. Bk. Bldg.,
St. Petersburg
Wright, Claude B.,
Equitable Bldg.....St. Petersburg
Wylie, Leroy A.,
210 Medical Arts Bldg.,
St. Petersburg

POLK COUNTY MEDICAL SOCIETY

Cordes, Henry B., President,
Box 84 Frostproof
Boulware, James R., Sec'y-Treasurer,
Box 367 Lakeland
Alexander, Omer R.,
25 Beymer Bldg.....Winter Haven
Besenbruch, Peter W.,
Orange St.....Davenport
Bird. D. Paul,
Box 414 Lakeland
Carefoot, G. H.....Ft. Meade
Clark, Samuel A.,
802 Marble Arcade Bldg., Lakeland
Cline, R. L.,
Box 462 Lakeland
Freeman, Grover C.,
Box 1202.....Lakeland
Fuller, Henry Mulberry
Gilbert, R. E.,
19 Postal Arcade.....Winter Haven
Griffin, J. D.,
203 Hartzell Lakeland
Hargrove, Julian L.,
Polk County Hospital.....Bartow
Harness, A. J.....Lakeland
Harris, E. A.....Brewster
Horton, Waldo,
539 Ave. B., N. W....Winter Haven
Hughes, Robert L.,
225 E. Main St.....Bartow
Hurlburt, C. J.....Bartow
Irons, F. E. Winter Haven
King, William W.,
Corner Main & Ky. Ave...Lakeland
Koon, Alpheus C.,
513 W. Lemon.....Lakeland
Lester, John G.,
Box 548 Lakeland
Lindsey, Sherrod A.....Ft. Meade
Martin, Emmett E.,
Wray Bldg. Haines City
Mooty, Ross H. Winter Haven
Murphy, C. H.....Bartow
Murphy, H. K.,
Polk & Main Sts.....Mulberry
Newman, Heber P. Bartow
Overstreet, George C.,
Marble Arcade.....Lakeland
Pearce, C. C. Mulberry
Pennington, B. Y.....Lake Wales
Ragsdale, Velpeau H.,
A. A. C. Co. Hospital.....Pierce
Roberts, Tenney H.,
328 N. Florida Ave.....Lakeland
Shafer, W. W. Haines City
Sherman, William E.,
716 W. Central Ave...Winter Haven
Simmons, Thos. G.,
Corlett Bldg. Auburndale
Simpson, W. T.....Winter Haven
Smith, Samuel F.,
Box 628 Lakeland
Stetson, A. G. C.,
Sullivan Bldg.....Lakeland
Sullivan, Raleigh R.,
1006 Marble Arcade.....Lakeland
Tillis, W. L.,
502 Mable Arcade.....Lakeland
Tinkler, B. R. Lake Wales
Tomlinson, J. P., Jr.....Lake Wales
Tomlinson, J. P., Sr.....Lake Wales
Vaughn, John W.,
Box 1021 Lakeland
Watson, Herman,
Box 944 Lakeland
Wilhoyte, Roy E.....Lake Wales
Williams, E. L.....Ft. Meade
Wilson, John F., Jr.,
Box 254.....Lakeland

PUTNAM COUNTY MEDICAL SOCIETY

Drexel, A. E., President.....Palatka
Warren, Edmund W., Sec'y-Treasurer,
Box 88 Palatka
Rosborough, D. Y. Palatka
Strong, S. B.,
Station Hospital, Ft. Oglethorpe, Ga.

ST. JOHNS COUNTY MEDICAL SOCIETY

Lockwood, Vernon A., President,
East Coast Hospital...St. Augustine
Potter, George W., Vice-President,
East Coast Hospital...St. Augustine
Britt, Reddin, Secretary,
Box 1226 St. Augustine
Grace, Charles C., Treasurer,
East Coast Hospital..St. Augustine
Chappell, F. V. Madison
Estes, Edgar S.,
305 First Natl. Bk. Bldg.,
St. Augustine
Fletcher, E. Gordon,
East Coast Hospital...St. Augustine
Spencer, J. J.....St. Augustine
Walkup, A. Clark,
116 St. George St.....St. Augustine
White, Herbert E.,
401 First Natl. Bk. Bldg.,
St. Augustine

ST. LUCIE-OKEECHOBEE-INDIAN RIVER-MARTIN COUNTY MEDICAL SOCIETY

Harrell, G. L., President....Vero Beach
Parker, J. D., Vice-President,
Box 942 Stuart
Davis, Claude L., Sec'y-Treasurer,
Okeechobee
Boothe, R. C.....Ft. Pierce
Clark, H. D.,
Ft. Pierce Bank & Trust Bldg.,
Ft. Pierce
Claxton, W. A.,
State Board of Health..Jacksonville
Council, Melton D.,
Arcade Building.....Ft. Pierce
Glidden, C. H. Ft. Pierce
Hardee, E. B.....Vero Beach
Hardie, Grover C.,
207½ Orange Ave.....Ft. Pierce
Lingo, M. J. Okeechobee
Newnham, J. A.,
Gramercy Sq. Apts.,
Irving Place.....New York, N. Y.
Whiddon, Lester L.,
200 Peacock Bldg.....Ft. Pierce

SARASOTA COUNTY MEDICAL SOCIETY

Patterson, John C., President,
Palmer Natl. Bk. Bldg.....Sarasota
Morton, Arthur O., Vice-President.
Commercial Court.....Sarasota
Harris, J. E., Sec'y-Treasurer,
224 Commercial Court.....Sarasota
Burgner, Benjamin H.....Sarasota
Burgner, Blanche A.....Sarasota
Cribbins, Orville H.,
224 Commercial Court.....Sarasota
Halton, Joseph,
Pineapple Ave. Sarasota
Hoskins, W. H. Venice
Johnston, W. J.,
215 Commercial Court.....Sarasota
Kennedy, David R.,
1st Bank & Trust Bldg.....Sarasota
Myers, Nicholas P.....Holopaw
Shelby, Edmund P.....Venice
Taylor, T. W.,
Walpole Bldg., Main St....Sarasota
Wilson, Cullen B.,
First Trust & Bank Bldg..Sarasota

SEMINOLE COUNTY MEDICAL SOCIETY

Knox, A. W., President,
Masonic Temple Sanford
Park, Charles L., Vice-President,
515 First Natl. Bk. Bldg....Sanford
Denton, John T., Sec'y-Treasurer,
Meisch Bldg. Sanford
Langley, W. T.,
Meisch Bldg. Sanford
Martin, John W.,
Box 95 Oviedo

Mitchell, Clifford M.....Sanford
Puleston, Samuel,
Brumley Puleston Bldg.....Sanford
Selman, G. S.,
Lake View Avenue.....Sanford
Smith, Henry D.,
Touchton Drug Co. Bldg...Sanford
Tolar, Julian N.,
First St. Sanford

SUMTER COUNTY MEDICAL SOCIETY

Albritton, Andrew B., President,
Wildwood
Mitchell, W. E., Sec'y-Treasurer,
Box 237 Coleman
Wood, Samuel C.....Leesburg

TAYLOR COUNTY MEDICAL SOCIETY

Baker, W. J., President.....Foley
Weeks, J. L., Vice-President.....Perry
O'Quinn, Charles A., Sec'y-Treasurer,
Perry
Bryan, W. H.....Scanlon
Ellis, John C.....Perry
Greene, Ralph J.....Perry
Warren, George H.,
Main St. Perry

VOLUSIA COUNTY MEDICAL SOCIETY

Howe, Roy, President,
222 Volusia Ave.....Daytona Beach
Davis, George A., Vice-President,
Dreka Bldg. DeLand
Rutter, Joseph H., Sec'y-Treasurer,
110 S. Palmetto Ave. Daytona Beach
Bouchelle, Louis B.....New Smyrna
Brown, L. V. L.....DeLand
Chandler, J. R.,
213 Orange Ave.....Daytona Beach
Chowning, W. C.,
111 Palmetto St.....New Smyrna
Clemmer, Charles A.,
Box 3236 Daytona Beach
Davis, C. W.,
231 Coates St.....Daytona Beach
Davis, Joseph B.,
Halifax District Hospital,
Daytona Beach
Dillard, T. H. DeLand
Doern, William Y.,
Box 5272.....Daytona Beach
Fogarty, Joseph N.,
Bin 5 Daytona Beach
Forster, Davis,
701 N. Orange Ave....New Smyrna
Glatzau, L. W.,
300 S. Beach St.....Daytona Beach
Green, George M.,
102½ S. Beach St....Daytona Beach
Henry, H. W.,
205 State Bank Bldg...New Smyrna
Howe, Raymond,
Box 1582 Daytona Beach
Johnson, Harry D.,
Box 1242.....Daytona Beach
Jones, Carroll B. New Smyrna
Merryday, Harry L.....Daytona Beach
Miller, B. E.,
412 Canal St.....New Smyrna
Miller, Harold E.,
412 Canal St.....New Smyrna
Miller, R. L.,
258½ S. Beach St...Daytona Beach
*†Munson, A. S.....DeLand
Myres, M. J.,
258½ S. Beach St...Daytona Beach
Pay, W. C.,
221 W. Rich Ave.....DeLand
Rawlings, James E.,
221 Orange Ave.....Daytona Beach
Stern, Maximilian,
223 Ocean Blvd.....Daytona Beach
Taylor, Joseph E.....DeLand
Wells, J. Ralston,
Woolworth Bldg.....Daytona Beach
West, Hugh DeLand
White, J. Blake,
Osceola-Gramatan Hotel,
Daytona Beach

WALTON-OKALOOSA COUNTY MEDICAL SOCIETY

Webb, E. Porter, President,
City Pharmacy.....Crestview
McSween, J. C., Vice-President,
DeFuniak Springs
Williams, A. G., Sec'y-Treasurer,
Lakewood
Huggins, E. L. Freeport
McDonald, C. W.....DeFuniak Springs
Spires, Ralph B.....DeFuniak Springs
Spires, W. G.....Darlington
Stephens, S. E.....Laurel Hill

INDIVIDUALS

*Anderson, Thomas S.,
Box 127.....Live Oak

*Deceased.
†Honorary Member.

CORRESPONDENCE

February 7, 1935.

To the Editor of the Florida Medical Journal, Jacksonville, Florida:

Following is a certified copy of the Minutes of the meeting of the Board of Commissioners of State Institutions, which met in Tallahassee January 2, 1935, for the purpose of discussing the situation at the State Hospital at Chattahoochee.

There was a previous short report made by the President of the Association, which appeared in the last issue of the Journal, and this copy of the Minutes is merely supplementing that report.

(Signed) Homer L. Pearson, M.D.,
President.

Tallahassee, Florida, January 2, 1935.

The Board of Commissioners of State Institutions met this day in the Executive Office with the Governor, Secretary of State, Attorney-General, Comptroller, State Treasurer, Superintendent of Public Instruction and Commissioner of Agriculture present.

The minutes of the last meeting were read and approved.

Florida State Hospital

Superintendency and Improvements — Florida Medical Association, Inc., Recommendations With Reference To.

This being the date the Board extended an invitation to Dr. Homer L. Pearson, President of the Florida Medical Association, Inc., Miami, Florida, to meet with it and discuss personally the matter of the superintendency of the Florida State Hospital, Dr. Homer L. Pearson, Miami; Colonel Preston Ayers, Superintendent, and Dr. J. H. Pound, Chief Physician, of the Florida State Hospital; Dr. H. E. Palmer, Dr. Fred C. Moor, and Dr. J. Kent Johnston, Tallahassee, Florida, appeared in the interest of the above discussion. Dr. Moor and Dr. Palmer made talks in the interest of appointing a physician as superintendent of the institution and the following paper was read by Dr. Pearson:

To His Excellency The Governor of the State of Florida and His Cabinet:

I would like first to express my thanks and appreciation for the privilege of meeting with you for the purpose of discussing the situation at the State Hospital at Chattahoochee.

It must be clearly understood and can be readily seen that I am not here for any personal gain, nor for personal or material gain for The Florida Medical Association, but I am here as a representative of the Florida Medical Association and am making a plea for the poor unfortunate mentally sick people of our great State.

I would like it understood also that the attack made by the Florida Medical Association on the policies of this Board relative to the State Hospital, must not be considered as an attack on any one member of this Board and that we have no personal grievance and that each member of this

Board is held in the highest esteem by our Association.

In order to keep the records straight, I am asking that a copy of this statement be entered in the minutes of this meeting and that I be furnished a certified copy of these minutes which will be published in the Journal of the Florida Medical Association.

To make this statement as concise as possible I will refer very briefly to the circumstances leading up to this controversy.

(1) The State Hospital in Chattahoochee is the largest hospital in the State, with a patient population of about four thousand.

(2) This unfortunate population is entitled to a highly developed therapeutic program.

(3) Since 1878 when the hospital was established all superintendents with the exception of three have been laymen, who have assumed charge without previous hospital training.

(4) The real advances made at the hospital were made under the superintendency of the three medical superintendents and in contrast little if any true institutional progress has been made under the direction of lay superintendents.

(5) The State of Florida requested a survey of the hospital by the National Committee for Mental Hygiene.

(6) The survey was made by Dr. Arthur M. Ruggles.

(7) Chief among his recommendations was "The chief executive officer must be a well qualified physician, an experienced psychiatrist, whose appointment and removal shall not be controlled by partisan politics," and he pointed out that this was not a standard set up by one man or one group, but was the result of years of experience and thought of the best mental hospital superintendents of all North America.

(8) There are one hundred seventy-five mental hospitals in the United States of America.

(9) One hundred seventy-three, or all save two, have medical men as superintendents. Florida is one of the two.

(10) The Florida Medical Association, in a resolution passed by its House of Delegates, petitioned this Board to appoint a medical superintendent.

(11) The Florida Medical Association is made up of one thousand of the Doctors of Florida.

(12) The Board appointed a layman as superintendent, said appointment being in direct opposition to the recommendations made by the National Committee for Mental Hygiene and also over the protest of the doctors of this State.

(13) We, the Doctors of the State of Florida, consider the action taken by this Board as a direct slap in the face and that you consider the recommendation made by the National Committee as merely "another scrap of paper."

(14) The Doctors of this State expect to continue their fight for a medical superintendent at the State Hospital, for we know we are fighting for the right, and fighting a battle for the poor, weak, and unfortunate mentally sick of our great State.

The Florida Medical Association recommends to the Board of Commissioners of State Institutions the following improvements for the State Hospital in Chattahoochee:

(1) The appointment of a well-trained physician and psychiatrist as superintendent. "While it is appreciated that many phases of mental hospital administration require per se no special medical training, there are, nevertheless, medical and certain psychiatric implications in every duty of a mental hospital superintendent. Even such non-medical functions as the ordering of equipment and supplies incurs professional understanding if the welfare of the patient is to be best served.

"Then, of course, the accord of hospital personnel is of prime consideration. Experience has taught that physicians are enabled to give their best services under the direction of an administrator with a thorough understanding of the medical viewpoint. Constant friction is to be expected in an institution where the work of physicians is to be influenced by orders from a layman. No such institution can expect to attract or hold for long the best type of medical personnel." H. E. Bullis, National Comm. for Mental Hygiene.

(2) The appointment of a business manager who is working under the superintendent and who can be dismissed by the superintendent if the occasion arises to warrant such action. Said business manager, under no conditions, can ever become superintendent.

(3) That the medical resident staff consist of at least twenty-four doctors who are selected, as far as possible, from the younger doctors and internes of this State.

(4) A high-class pathologist should be employed, preferably one especially trained in neuropathology.

(5) We recommend that the present method of transporting patients from the various parts of the State to the hospital be discontinued. This improvement has been made.

(6) That a hospital room or rooms be prepared in various cities throughout the State for the potential patients under observation, rather than placing them in the county jails.

(7) We recommend the development of child guidance clinics in order that the problem child who, untrained, furnishes the population for insane asylums later on, may be classified and the necessary mental hygiene preventive measures applied.

(8) It would be well for this State to create a State Lunacy Commission, composed of doctors who are trained in psychiatry, to serve as an impartial board in medical-legal matters, criminal and otherwise, and by their recommendations influence trial procedures into a dignified procedure rather than a continuous repetition of the disgraceful things in murder and other trials that have occurred in the past.

(9) This Board should ask the State Medical Association to appoint a visiting staff of representative men from the various specialties. These men should be given traveling expenses and a reasonable per diem compensation for regular visits to the hospital.

(10) We would respectfully bring to your attention the fact that when a hospital reaches the population of three thousand patients its operation becomes cumbersome and the time has come for the creation of another hospital which should be located in the central part of the State near an urban center.

Back of all these recommendations is the suggestion that the Florida Medical Association will be glad to tender its services through a committee appointed from its best qualified men, to visit the hospital from time to time and make recommendations for the betterment of conditions there.

Respectfully submitted,

(Signed) Homer Pearson, M.D.,

President, Florida Medical Association, Inc.

The Board did not agree with the Medical Association in its recommendation with reference to a physician being appointed as superintendent, and stated to those physicians present that it was still of the opinion that a layman who was a good business manager should be superintendent of the Florida State Hospital,leaving the physician's entire time to the care of the patients. The Board recommended, however, that a committee of the members of the Florida Medical Association, Inc., make at least one visit to the institution for the purpose of assisting the Board in making recommendations to the Legislature in the interest of the betterment of the institution. It also extended an invitation to any and all members of the Association to visit the institution at any time.

The Board made it very clear to Dr. Pearson that on account of lack of funds it had not been possible to put into effect many of the worthy recommendations of Dr. Arthur M. Ruggles and of the Florida Medical Association.

The Board then adjourned, subject to call.

(Signed) David Sholtz,

Governor and Chairman.

(Signed) J. P. Newell,

Secretary.

State of Florida, }
County of Leon. }

I, J. P. Newell, Secretary to the Board of Commissioners of State Institutions of the State of Florida, hereby certify that the foregoing is a true and correct excerpt of the minutes of the Board of Commissioners of State Institutions of the State of Florida of January 2nd, 1935, with reference to the Florida State Hospital.

J. P. Newell.

Sworn to and subscribed before me,
this 22nd day of January, A. D. 1935.

Joe Frank,

Notary Public.

My Com. Exp. 4-20-35.

STATE NEWS ITEMS

Dr. Robert McIver of Jacksonville presented a paper on "Surgical Lesions of the Kidney", illustrated with lantern slides, before the Thomas County Medical Society at Thomasville, Georgia, on December 20.

* * *

Dr. Gerard Raap of Miami has returned home from a short trip to Memphis, Tenn., where he attended a meeting of the Radiological Society of America.

* * *

Dr. F. M. Fernandez, formerly of Havana, Cuba, announces the opening of offices at 343 Ingraham Building, Miami.

* * *

Colonel Raymond Sanderson of Jacksonville has been ordered to active duty training in the Medical Reserve as Flight Surgeon at Candler Field, Atlanta.

Dr. L. W. Elgin of Miami announces the removal of his offices from the Huntington Building to 330-331 Ingraham Building. Dr. Elgin will limit his practice to urology.

* * *

The 1935 annual Clinical Congress of the American College of Surgeons will be held in San Francisco, October 28-November 1.

* * *

A sectional meeting of the American College of Surgeons for Alabama, Georgia, Florida, Tennessee, Mississippi and Louisiana, will be held in Birmingham, Alabama, March 7, 8, 1935. Headquarters, Tutwiler Hotel.

TENTATIVE PROGRAM

First Day

8:00- 9:00	Registration.
9:00-12:00	Clinics.
9:00-12:00	Hospital Conference.
12:30- 2:00	Medical Motion Pictures.
2:30- 5:00	Hospital Conference.
5:00- 5:30	Annual Meeting of the Fellows of the College.
7:00- 8:30	Subscription Banquet.
8:30-10:30	Scientific Meeting, General Surgery.
8:30-10:30	Scientific Meeting, Eye, Ear, Nose and Throat Surgery.

Second Day

9:00-12:00	Clinics.
9:00-12:00	Hospital Conference.
12:30- 2:00	Medical Motion Pictures.
2:30- 5:30	Scientific Meeting, General Surgery.
2:30- 5:30	Scientific Meeting, Eye, Ear, Nose and Throat Surgery.
2:30- 5:00	Hospital Conference.
8:00-10:00	Community Health Meeting.

A cordial invitation is extended to all interested surgeons and hospital officials.

COMPONENT COUNTY SOCIETIES

ALACHUA COUNTY MEDICAL SOCIETY

THE ALACHUA COUNTY MEDICAL SOCIETY BECAME THE TWENTY-THIRD SOCIETY TO REPORT 100% MEMBERSHIP DUES FOR 1934. THE OFFICERS OF THE SOCIETY FOR 1934 WERE: J. L. SUMMERLIN, PRESIDENT: C. D. WHITAKER, VICE-PRESIDENT; AND HARRY M. MERCHANT, SECRETARY-TREASURER.

BROWARD COUNTY MEDICAL SOCIETY

At the annual meeting of the Broward County Medical Society, the following officers were elected to serve for 1935:

President—O. C. Brown, Ft. Lauderdale.
Vice-President—Ralph Lingeman, Ft. Lauderdale.
Sec'y-Treasurer—Robert E. Blount, Ft. Lauderdale.

DADE COUNTY MEDICAL SOCIETY

At the February 1 meeting of the Dade County Medical Society, the following program was presented:

"Fractures of the Spine", Don C. Eskew, Miami.
"Gonococcus Aortitis with Aneurysm and Bicuspid Aortic Valve. Preliminary Case Report," Max Dobrin, Miami.

The following resolution was adopted by the Dade County Medical Association, Inc., in regular session:

"Whereas, God in His infinite wisdom and mercy has seen fit to call one of our most beloved members, Dr. J. M. J. Luke, to his reward, and

"Whereas, by his untiring and unselfish devotion to his duties in the practice of medicine and surgery, and his many sacrifices in the interests of charity, has endeared himself to all those who knew him, and

"Whereas, we, the members of the Dade County Medical Society, feel most deeply the loss of this, our Brother and friend, therefore be it

"RESOLVED: That the Dade County Medical Society hereby express its sorrow in the passing of Dr. J. M. J. Luke; that a copy of this resolution be sent to his wife; that a copy be entered on the minutes of this Society; and that same be published in the Journal of the Florida Medical Association and in the local press."

DE SOTO-HARDEE-HIGHLANDS COUNTY MEDICAL SOCIETY

The January meeting of the DeSoto-Hardee-Highlands County Medical Society was held at Avon Park. Election of officers for 1935 was held, which resulted as follows:

President—Charles H. Kirkpatrick, Arcadia.
Vice-President—Ben D. Spears, Wauchula.
Secy.-Treasurer—L. W. Martin, Sebring.
Censor—Morris J. Alexander, Zolpho Springs.
Delegate to State Meeting—W. H. Peacock, Wauchula.

Alternate Delegate—L. W. Martin, Sebring.

The scientific feature of the meeting consisted of a paper presented by Dr. Guy O. Brewster of Sebring on "Binocular Vision as Applied to the General Practitioner." Dr. Peacock gave a very interesting case report of a peculiar type of urticaria in a boy 7 years of age.

DUVAL COUNTY MEDICAL SOCIETY

At the meeting of the Duval County Medical Society held at the Mayflower Hotel, Jacksonville, February 5, Doctor David D. Berlin of Boston was guest speaker. Dr. Berlin presented "The Present Status of Total Thyroidectomy in the Treatment of Congestive and Anginal Heart Failure."

ORANGE COUNTY MEDICAL SOCIETY

RESOLUTION

Dr. Gaston Holcombe Edwards, one of Florida's most outstanding surgeons, died in Orlando, December 29th, after a very brief illness.

Dr. Edwards began the practice of medicine in Orlando in 1909, and has been a member of the Orange County Medical Society since that time. He was also a member of the Florida Medical Association and the American Medical Association; a fellow of the American College of Surgeons and the Southeastern Surgical Association, Southern Medical Association, and a member of the Association of Atlantic Coast Line Railroad Surgeons.

Dr. Edwards was born in Granby, Connecticutt, August 18th, 1875, the son of Dr. George Edwards and Ann Eliza Holcombe Edwards. He is survived by his widow, Adair Irvin Dunn Edwards, and three children, Mary Adair Edwards, George W. Edwards, and Warren Hardin Edwards.

He received the degree of Ph.B., M.S., and and M.D. from the Sheffield Scientific School and Medical School of Yale University. After two years' hospital service in Kings County Hospital, New York, he spent a year of travel in the West Indies and South America. He was in the medical service of the U. S. Government from 1906 to 1909, acting as surgeon to the Colon Hospital at Colon, Panama. In 1918 and 1919, Dr. Edwards served with the American Red Cross, acting as deputy commissioner to Serbia, with headquarters at Belgrade. He was decorated by King Alexander with the third order of St. Sava and the Serbian Red Cross. For refugee work in Macedonia, he was made a member of the Order de Lutra. He received the French "Medialle Commerate" for service in France.

Dr. Edwards was president of the Orange County Medical Society in 1916. He is a past-president of the Florida Medical Association, serving in that capacity in 1931 and 1932. He was a delegate to the American Medical Association from Florida in 1930 and 1931, and was a delegate to the Florida Medical Association from Orange County and Chairman of the Council of the Florida Medical Association at the time of his death.

He is a past-president of the Orlando Kiwanis Club and a past-district governor of that organization.

In the passing of Dr. Edwards, the medical profession lost one of its most valued and beloved members. While yet in love with life and enraptured with the world, he lay down and fell into that dreamless sleep and passed into silence and pathetic dust. Yet, after all, it is the belief that all things happen for the best, just in the happiest, sunniest hour of all the voyage, while eager winds are kissing every sail, to dash against the unseen rock, and in an instant hear the billows roar above a sunken ship. For whether in mid-sea or among the breakers of the farther shore, a wreck at last must mark the end of each and all, and every life, no matter if its every hour is rich with love and every moment jeweled with joy, will at its close, become a tragedy as sad and deep and dark as can be woven of the warp and woof of mystery and death.

This brave and tender man in every storm of life was oak and rock, but in the sunshine he was vine and flower. He was friend of all heroic souls. He climbed the heights and left all superstition far below, while on his forehead fell the golden dawning of the grander day.

This earth is a vast graveyard where untold millions of men are buried, but, out of the untold myriads who pass into forgetfulness every decade, the race holds a few names embalmed in undying amber.

His heart was wrung at the sight of suffering and he had tears for the erring and oppressed. He had the love that gave for the joy of giving, asking nothing in return. He knew nothing but to speak the truth and do his work, and would have said the day before, "Tomorrow I may go—where? I know not but I am not afraid. All I seek is a greater understanding."

He needs no epitaph other than his name, Gaston Holcombe Edwards, which, to those who knew him, is symbolical of truth, love of nature, things Godly, and faith in humanity.

Man is neither master of his life nor of his fate. He can but offer to his fellow man his efforts to diminish human suffering; he can but offer to God his indomitable faith.

So, whereas the passing of this beloved fellow of the Orange County Medical Society has brought great grief and sorrow to its members, therefore,

Be it Resolved: That the Orange County Medical Society express its sorrow in the passing of Dr. Edwards and extend its sympathy to the bereaved family; that this resolution be spread upon the minutes of this society as a reminder to us and be published in the Journal of the Florida Medical Association.

L. C. Ingram, Chairman;
T. A. Neal,
W. H. Spiers,
Committee.

PASCO-HERNANDO-CITRUS COUNTY MEDICAL SOCIETY

Dr. George R. Creekmore of Brooksville entertained the members of the Pasco-Hernando-Citrus County Medical Society on Thursday evening, January 10. A splendid dinner was served his guests at the Tangerine Hotel, which was followed by a business meeting. Dr. S. C. Harvard of Brooksville presented a paper on "Cancer of the Breast." The election of officers for 1935 was held, which resulted as follows:

President—A. C. Coogler, Brooksville.
Vice-President—J. T. Bradshaw, Lake Jovita.
Vice-President—P. J. Hudson, Crystal River.
Secy.-Treasurer—John J. Bourke, Dade City.
Delegate to State Meeting—George A. Dame, Inverness.
Alternate Delegate—S. C. Harvard, Brooksville

ST. JOHNS COUNTY MEDICAL SOCIETY

The following officers have been elected and installed by the St. Johns County Medical Society:

President—Reddin Britt, St. Augustine.
Vice-President—Charles C. Grace, St. Augustine.
Secretary—John L. Bennett, St. Augustine.
Treasurer—Walter G. Potter, St. Augustine.
Delegate to State Meeting—H. E. White, St. Augustine.
Alternate Delegate—A. C. Walkup, St. Augustine.

WOMAN'S AUXILIARY

TO THE
FLORIDA MEDICAL ASSOCIATION, INC.
State Editor
Mrs. S. M. Copelano
1356 Willowbranch Ave.,
Jacksonville, Florida

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Mrs. E. W. Veal, Presideot-elect *Jacksonville*
Mrs. Homer Pearson, Vice-President *Miami*
Mrs. W. A. Weed, Secretary-Treasurer *Lakeland*
Mrs. G. C. Tillman, Corresponding Secretary . . . *Gainesville*
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Mrs. J. Ralston Wells, Public Relations . . . *Daytona Beach*
Mrs. J. E. Taylor, Hygeia *DeLand*
Mrs. Arthur Walters, Finance *Miami Beach*
Mrs. S. M. Copelano, Press and Publicity *Jacksonville*

Duval County

A lecture on cancer, illustrated with slides by Dr. Gerry R. Holden, state chairman of the cancer prevention program, and Dr. Frederick J. Waas, prominent surgeon of Jacksonville, was given at the Woman's Club in South Jacksonville January 18.

The meeting was well attended by various classes of people and received much favorable comment.

Mrs. E. W. Veal, public relations chairman of Duval County Medical Auxiliary was in charge of arrangements.

The Woman's Auxiliary to the Duval County Medical Society held its January meeting Thursday afternoon in the home of Mrs. John H. Mitchell, on Avondale Avenue, Mrs. Gordon H. Ira, Mrs. J. H. Owens and Mrs. C. E. Royce acting as co-hostesses.

The meeting was presided over by the president, Mrs. Gordon H. Ira, and opened with the Club Woman's prayer read by Mrs. E. W. Veal. In the absence of the secretary, Mrs. O. P. Broadbent, Mrs. Veal was asked to read the minutes of the last meeting. The treasurer, Mrs. Edward Jelks, read the treasurer's report.

A most interesting report of the Southern Medical convention held in San Antonio, Texas, November 13 to 16, was given by Mrs. Edward Jelks.

Mrs. S. M. Copeland announced that Mrs. Jelks had been elected parliamentarian of the Southern Medical Auxiliary, an honor that not only reflects credit to the Auxiliary but to the state.

Interesting reports from chairmen of all standing committees were given.

FLORIDA MEDICAL ASSOCIATION

MAY 13, 14, 15, 1935

CONVENTION HEADQUARTERS HOTEL

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PLEASE LET US HAVE
YOUR RESERVATION REQUEST EARLY

A suggestion was made by Mrs. Neil Alford for us to try to interest other organizations in the value of "Hygeia" as a health magazine; the only magazine that has been endorsed by the American Medical Association.

There being no further business, the meeting was turned over to the program chairman, Mrs. A. K. Wilson, who introduced the guest speaker, Dr. Gordon H. Ira, chairman of the State Medical Advisory Board.

Dr. Ira stated that Mrs. Wilson had asked him to discuss the seven charges sent out by Dr. Homer Pearson, President of the State Medical Society. He said, "These charges grew out of a meeting of the Advisory Committee with the State Auxiliary officers at Bartow last September. We were the guests of Mrs. McMurray, your State President, and along with the business of the day we enjoyed a very bounteous, and delicious barbecued chicken dinner. These seven charges cover seven entirely different phases of your work:

(1) The first charge is a very important one and must be carried out individually. It is, "Let each member at all times hold herself in readiness to serve on health committees of any outside organization."

I have corresponded with Dr. Olin West, Chairman of the National Advisory Board, and with Mrs. Robert Tomlinson, President of the Auxiliary to the American Medical Association, and both emphasize this point. Mrs. Tomlinson says, "We are urging every member of the Auxiliary to sit in on every possible meeting and to avail themselves of every opportunity to furnish speakers of known repute for meetings of these organizations."

(2) The second article in your charge is "Assist in the dissemination of good health literature by means of an enlarged circulation of Hygeia."

First, let me emphasize the importance of educating the public concerning medical matters. One of the reasons why there are many, many more doctors now than fifty years ago, is because the public knows so much more about diseases, and more people, call more doctors, for many, many more things than they did fifty years ago. If the public was as ignorant about medical matters as they were fifty years ago there wouldn't be half as many doctors employed as there are.

Second, let me point out to you another task concerning Hygeia. First, however, you are to be congratulated upon the number of subscrip-



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One of a series of advertisements prepared and published by PARKE, DAVIS & CO. in behalf of the medical profession. This "See Your Doctor" campaign is running in the *Saturday Evening Post* and other leading magazines.



Dear Dr. Armstrong:

Nothing would do but that Bobby bring this to you himself, in person.

It's partly because you and he became such good pals when you pulled him through that siege last summer.

But more than that, he had heard his Dad and me talking, and he knew that this was different from the ordinary check we send out—that it deserved something more than the slapping on of a stamp and routine delivery by the mail man.

And Bobby is right.

You couldn't have done more if he had been your own child. We've always known this, and yet your bill has lain here, put off month after month, while bills for other things have been paid.

It wasn't that we didn't want to pay you, for we did. But after we bought those things necessary to keep us going—food, and clothing, and coal—our bank balance was pitiful to behold.

Now, thank heavens, things are a little brighter. And here at last is our chance to send you something more than thanks for all you did for Bobby and for us.

Sincerely,

Mrs. J____ B____

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tions you have. The Hygeia work has been carried on here better than in most counties. The task that I spoke of is this: The National Auxiliary and the National Advisory Board recognize the value and importance of Hygeia in educating the laymen. The Hygeia work in every county would progress much faster if a little missionary work were done by the Auxiliary members among the members of the County Medical Societies.

(3) We come next to the third charge, namely, "Give your whole-hearted cooperation to the program of Cancer Prevention, and arrange if possible one public presentation of Cancer Prevention material in your county, several if advisable, at a time acceptable to the State program.

Here is another shining example of how educating the public will make work for the doctor. One is apt to say, "Why tell the public so much, it will just decrease the doctor's work!" Just the opposite. While you are helping the other fellow—you are in turn helping yourself. There are fewer cancer deaths today than in the past, yet we hear of many more than we used to. Why? Because they are diagnosed. Thousands upon thousands of people are having examinations because they know about cancer, and thousands are being saved from an untimely death because of their knowledge that led them early to their physician.

The Chairman of the State Cancer Committee, Dr. Gerry Holden, is more than willing to cooperate, with the Federated Women's Clubs putting on a Cancer Education Program under the direction of Mrs. Carl Weber Illig, Jr.; it would look like this charge particularly could be carried out very successfully. It is something everyone is interested in, and with the proper publicity and cooperation with different clubs, a great deal of good can be accomplished. The date for the meeting should be set ahead sufficiently far to lay your plans well. Pamphlets can be secured for free distribution. This can be given considerable publicity among different Women's Clubs.

You can secure most of them for less than 2c a copy. So much then for this one very important charge.

(4) The fourth charge is "Assist in organization of new county auxiliaries." You can visualize a map of Florida with eight out of sixty-seven counties organized. The plan is to have a "flying squadron" consisting of several doctors and several auxiliary members meet with the wives of the members of county societies and help them

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—Proc. Soc. Exp. Biol. and Med., 1934, **32**, 241-245.

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* "Pharmacology of Inflammation: III. Influence of Hygroscopic Agents on Irritation from Cigarette Smoke," as reprinted from Proc. Soc. Exp. Biol. and Med., 1934, 32, 241-245. ☐

** Two packages of Philip Morris English Blend cigarettes. ☐

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The KLIM cookbook (Reinforced Diet Recipes), gives you a simple means of readily prescribing these elements in concentrated diets in cereal, beverage, soup, etc. Taste, bulk and appearance of foods are not changed. We will gladly forward as many copies of the booklet as you desire for patient distribution, together with samples of KLIM.

A Typical Recipe from "Reinforced Diet Recipes"

CREAM OF TOMATO SOUP

1 cup thin tomato soup or
1 cup diluted canned tomato soup
6 tablespoons KLIM
¼ teaspoon salt

Blend tomato soup, 6 tablespoons KLIM and ¼ teaspoon salt. Bring to scalding point and serve. Volume: 1 cup.

This recipe furnishes ½ cup of milk (84 calories) over normal recipe.

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THE BORDEN COMPANY Dept. 240, MADISON AVENUE, NEW, YORK, N. Y.

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organize. I trust that your auxiliary will be called upon to help organize one or two societies this year.

(5) And fifth "Hold yourself in readiness to give as wide support as possible when called upon by the State Legislative Committee."

With socialized medicine at our door, it is hard to predict just what the practice of medicine will be five to ten years from now. Certainly different from its present form. I have no more to say to you with reference to this charge, except to urge that you carry out any request of the legislative committee.

(6) And now we come to the charge that I want to emphasize. A task that I hope you will take an individual interest in and make enough of it so that it will become a city ordinance. Here is a work that can bring the State Auxiliary plenty of credit and commendation at the next National Convention, if you will take an active enough interest to put it across. It is something well worth while, namely: "Present to as many organizations as possible the talk on 'The necessity of Health Cards for Household Servants.'" During the past six years I have examined 27 servants for employment in one home. Practically everyone had come recommended, and without a single exception all denied having ever had a venereal disease. The results were that out of these 27 examined 9 of them had syphilis. On two occasions when, because of the high recommendation and healthy appearance of these servants they were allowed to go to work before their blood tests were returned, and after finding them positive, the danger was more forcibly presented. One sees the folly in employing servants to handle your food and care for your children without a medical examination. The public restaurants are safer in this respect than many homes, for all public food handlers are required by law to have health cards.

Numerous instances could be cited where diseases have been contracted from servants. Little girls are unusually susceptible to one form of venereal disease and all children are in grave danger of contraction if exposed directly to any servant with tuberculosis. The layman is more familiar with the spread of this disease. You will be furnished with this three-minute talk, which I trust will be read before every Woman's Organization in Jacksonville, with finally a request that it be made a city ordinance requiring household servants to furnish health cards.

J. K. ATTWOOD, Pharmacist
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(7) The seventh and last charge, "Use at least one study envelope during the year." These are for your information and will prove of much value to you if you will choose one or more and assign topics to different members for presentation.

Any of the talks would be suitable. I believe if you became really interested in one of them you would want to read all of them. You can learn a great deal about communicable diseases, defects in children, etc.

In conclusion let me emphasize all of the charges, but especially the *Hygeia Work*, the *Cancer Prevention Program*, and most particularly the *Examination of Household Servants*. Have the three-minute talk read as many times as possible in the coming year.

Following Dr. Ira's talk, Mrs. J. H. Owens and Mrs. J. W. Hayes read interesting papers on the Nobel prize winners.

At the conclusion of the meeting the social chairman, Mrs. Theodore G. Croft, presented the game "Lucky," all the members participating in the contest. The winner of high score was Mrs. H. O. Peyton who received a beautiful green pot plant.

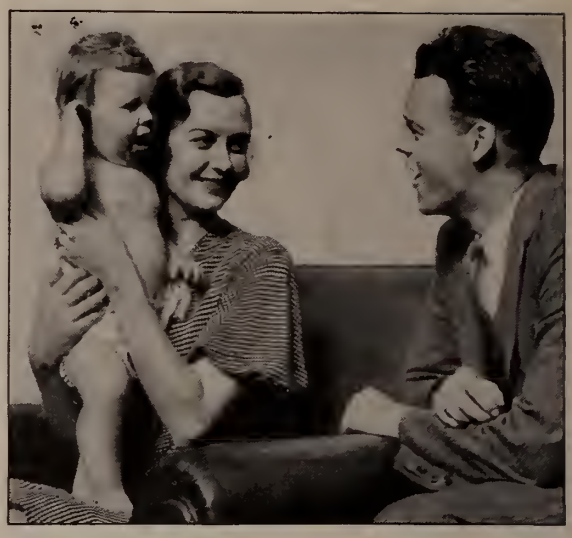
After the contest the members and guests were invited into the dining room for tea. The beautifully appointed table was overlaid with an exquisite lace cover and centered with a crystal bowl of snow white chrysanthemums. Tall green candles burned in crystal candelabra on either side. A handsome silver service with trays of attractive cakes frosted with green icing and open-face sandwiches together with nuts and mints adorned the table. A green and white color scheme predominated throughout the house. Mrs. Lucien Y. Dyrenforth presided over the silver service, pouring tea.

* * *

Marion County

Marion County Auxiliary held their January luncheon meeting at the home of the President, Mrs. E. G. Lindner, in Ocala. A short business meeting was held before lunch and the afternoon was devoted to perfecting plans for entertainment at the State meeting.

The December meeting found attendance low due to illness, and with the exception of a small business session, the meeting was purely social. The hostess was Mrs. R. D. Ferguson, who entertained with lunch at Silver Springs Grill.



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SCHEDULE OF MEETINGS—COMPONENT SOCIETIES FLORIDA MEDICAL ASSOCIATION

COUNTY SOCIETY	SECRETARY	MEETINGS				Dues Paid.
		Date	Time	Place	Luncheon?	
Alachua	Harry M. Merchant, M.D., Gainesville.	2nd Tuesday	12:00 Noon	White House Gainesville	Yes.	
Bay	Allen H. Miller, M.D., Millville.					25%
Brevard	I. K. Hicks, M.D., Melbourne.	2nd Tuesday		Varies	Yes.	
Broward	Robert E. Blount, M.D., Ft. Lauderdale.	Last Wednesday.	8:00 P.M.	Elks' Hall Ft. Lauderdale	No.	
Columbia	T. H. Bates, M.D., Lake City.	1st Monday	7:30 P.M.	Blanche Hotel Lake City		100%
Dade	Robert T. Spicer, M.D., Miami.	1st Friday	8:30 P.M.	Club Room Huntington Bldg. Miami	Occasionally.	28%
DeSoto-Hardee-Highlands	L. W. Martin, M.D., Sebring.	2nd Tuesday	8:00 P.M.	Varies	Yes.	
Duval	Charles B. Mabry, M.D., Jacksonville.	1st Tuesday	8:15 P.M.	Mayflower Hotel Jacksonville	No.	33%
Escambia	J. M. Hoffman, M.D., Pensacola.	2nd Tuesday	8:00 P.M.	Board of Health Building Pensacola	No.	
Hillsboro	John S. Helms, Jr., M.D., Tampa.	1st Tuesday	8:00 P.M.	Tampa Municipal Hospital Tampa	No.	
Jackson	Lewis Pierce, M.D., Marianna.	2nd Tuesday	7:30 P.M.	Hotel Chipola, Marianna	Yes.	
Lake	W. L. Ashton, M.D., Umatilla.	1st Thursday	12:30 P.M.	Eustis	Yes.	68%
Lee	H. Quillian Jones, M.D., Ft. Myers.	3rd Friday	7:30 P.M.	Lee Memorial Hospital Ft. Myers	No.	80%
Leon-Gadsden-Liberty-Wakulla-Jefferson	O. G. Kendrick, M.D., Tallahassee.	Quarterly	3:00 P.M.	Varies	Yes.	71%
Madison	Geo. O. Davis, M.D., Madison.					
Manatee	W. D. Sugg, M.D., Bradenton.	3rd Tuesday	7:00 P.M.	Whitfield Country Club Bradenton	Yes.	
Marion	Richard C. Cumming, M.D., Ocala.	3rd Thursday	12:30 P.M.	Marion Hotel Ocala	Yes.	80%
Monroe	W. R. Warren, M.D., Key West.	1st Sunday	9:00 P.M.	Varies	Yes.	
Orange	John A. Pines, M.D., Orlando.	3rd Wednesday	8:30 P.M.	Varies	No.	
Palm Beach	Lloyd J. Netto, M.D., W. Palm Beach.	4th Monday	8:00 P.M.	Good Samaritan Hospital W. Palm Beach	No.	40%
Pasco-Hernando-Citrus	John J. Bourke, M.D., Dade City.	2nd Thursday	7:00 P.M.	Varies	Yes.	46%
Pinellas	O. O. Feaster, M.D., St. Petersburg	1st Friday	8:00 P.M.	Assembly Room, 5th floor, P. & L. Bldg. St. Petersburg	No.	64%
Polk	J. R. Boulware, Jr., M.D., Lakeland.	2nd Wednesday in Feb., Apr., June, Aug., Oct., Dec.	1:00 P.M.	Lakeland	Yes.	
Putnam	E. W. Warren, M.D., Palatka.	2nd Thursday	7:00 P.M.	James Hotel, Palatka	Yes.	40%
St. Johns	Reddin Britt, M.D., St. Augustine.	3rd Tuesday	8:30 P.M.	Varies	Yes.	7%
St. Lucie-Okeechobee-Indian River-Martin	J. D. Parker, M.D., Stuart.	3rd Thursday	8:00 P.M.	Varies	Yes.	
Sarasota	J. E. Harris, M.D., Sarasota.	2nd Tuesday	8:30 P.M.	Varies	Occasionally.	93%
Seminole	J. T. Denton, M.D., Sanford.	2nd Monday	7:00 P.M.	City Hospital Sanford	Yes.	
Sumter	W. E. Mitchell, M.D., Coleman.	2nd Tuesday		Varies	No.	
Taylor	C. A. O'Quinn, M.D., Perry.	Last Friday	8:00 P.M.	Dixie-Taylor Hotel Perry	Yes.	
Volusia	Hugh West, M. D., DeLand	2nd Tuesday	7:30 P.M.	Varies	Yes.	
Walton-Okaloosa	A. G. Williams, M.D., Lakewood.	3rd Thursday	8:00 P.M.	Varies	Occasionally.	

NOTE—Secretaries: Please submit information to complete the above schedule.



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SIXTY-SECOND ANNUAL MEETING, OCALA, MAY 13, 14, 15, 1935

THE JOURNAL
OF THE
Florida Medical Association, Inc.

OWNED AND PUBLISHED BY THE FLORIDA MEDICAL ASSOCIATION, INC.

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NO. 9

Jacksonville, Florida, March, 1935

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Florida Medical Association, Ocala, May 13, 14, 15, 1935.
American Medical Association, Atlantic City, June 10-14, 1935.
Southern Medical Association, St. Louis, November 19-22, 1935

Entered as second-class matter under Act of Congress of March 3, 1879, at the Postoffice at Jacksonville, Florida, October 23, 1924



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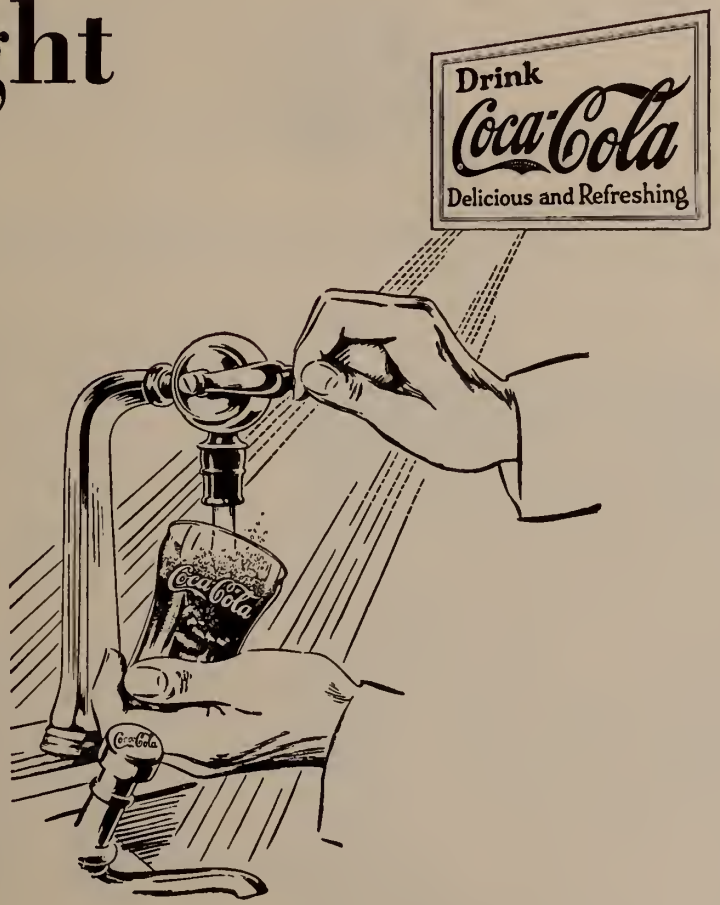
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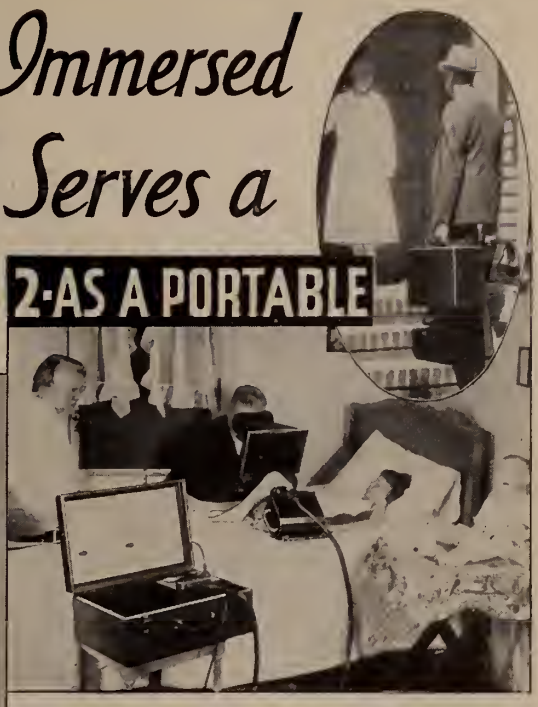
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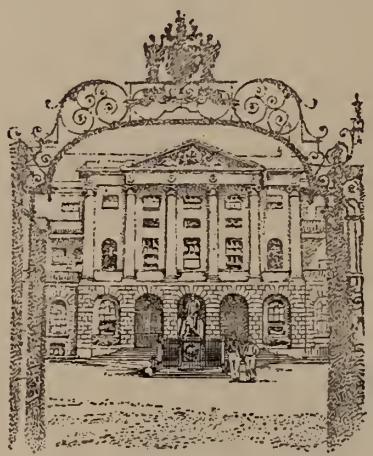
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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
PUBLISHED MONTHLY

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SUGGESTIONS AS TO CARE OF BRAIN INJURY CASES*

RALPH N. GREENE, M.D.,
Jacksonville.

The occurrence of thirty thousand fatal automobile accidents in the United States every year with injury alone increasing the number of cases to one million, and because of the high mortality rate, seems to justify consideration of the different methods of treating head injury cases.

I have prepared here a map, the details of which you cannot see very well, showing every fatal automobile accident case in the State of Florida in 1927. These cases were all followed up by correspondence with either the doctor, hospital or undertaker involved. The circles represent the cities and number of deaths in the city, and the red cross indicates the geographical location of the appalling accidents, and the black dots indicate deaths that occurred at the time of the accident.

Here our cases have been carried into Florida from Virginia and a very considerable number from Georgia. There are similar instances in west Florida where cases have had a rather long transportation.

It is the belief that in many automobile head injury cases, the patients, suffering as they are from shock and in coma, may be placed in bed in a hotel or in a home and left specifically alone, and that a very considerable percentage of that group will regain consciousness and enter into a very satisfactory convalescence within a comparatively short time, perhaps four hours.

It is also the belief from the examination of these transfer cases, that certainly there must have been a number of cases in which this condition of intracranial pressure was increased because of the stress incident to the ambulation of an unconscious subject. Considerable thought has been given to the fact that many automobile accident patients presumably mildly injured and not watched with great frequency as to pulse, temperature and respiratory rate, are suddenly found to have developed medullary decompensation with hyperpyrexia, and that at a time when surgical intervention would probably be of no avail.

Mention has been made of three cases that occurred at Gainesville. These cases were under the active care of Doctors Thomas and J. Maxey Dell, Jr., with Dr. Edward Jelks and myself there in the capacity of consultants. These young men were in a terrible automobile accident in which the structure above the chassis of a Packard automobile was practically cleared off to the floor board. One man was found unconscious on the concrete highway sixty or more yards from the accident. The first case was admitted to the hospital at 1 :40 a. m. October 22nd. This patient showed rapid evidence of medullary decompensation. Pulse, temperature and respiratory rates were taken every thirty minutes day and night. Also there seems to be a notation on the graphic chart that blood pressure readings were of no value. The first operation was done at 10:40, Oct. 24th, the second day after admission. He was found to have extradural hemorrhage with considerable brain swelling. After operation temperature continued to rise and second operation was done October 25th at 4:40 a. m. after admission three days previously, at 1 :40 a. m., at which time he had a temperature of 106, pulse rate 100 and respiratory rate of 65. Not a very encouraging proposition, however. He was in deep coma and the second decompression was rapidly done without any anesthetic at all. Clots were eliminated and additional space provided for brain swelling. As you will note he went into an uneventful convalescence and is perfectly well today.

The second case showed a very turbulent career with gradual descending of temperature rate. There was no great change in systolic and diastolic blood pressure, but persistent bradycardia. Also from the beginning there was a total paralysis of the urinary bladder. I believe that all cases that fail to void from the beginning and have to be catheterized should be decompressed. This patient likewise was watched every thirty minutes day and night. He had a most turbulent career.

It was apparent that any operative procedure would have to be done with measures causing little disturbance to the patient. X-rays were made by placing the film to the side of the head

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in bed and without moving the patient. He was given hypertonic salt solution, and controlled with sodium amytol when excited rather than morphine, sodium amytol having a more satisfactory therapeutic effect. This young man, following a most turbulent career, came out without any surgical interference whatsoever. The question of anoxemia came in of course because of the swelling of the brain and disturbed respiratory rate, and indirectly from the persistent bradycardia that occurs in this condition. If hypostatic pneumonia had developed the results probably would have been one hundred per cent fatal. In these cases with evidence of lung consolidation the head was placed at a low angle. It is surprising the amount of secretion that will run out of the mouths of these patients. And all lung symptoms promptly cleared up.

We feel, therefore, that with this limited number of cases and the opportunity of observing a large group of head injury cases over a period of years, we are justified in stating that head injury cases must be placed in bed quickly and disturbed as little as possible, realizing that in rest alone the patient is safe. If restless he is in jeopardy.

The matter of skull fracture is of no particular significance. Any depressed fracture can be diagnosed by the palpating finger. We believe that moving these patients just to have an x-ray developed is more harmful than helpful in making an early diagnosis. If the patient is under the care of a doctor who has the facilities to take temperature, pulse and respiratory rate every thirty minutes day and night, then he can give hypertonic salt solution to shrink the brain and lower intracranial pressure. Many cases will come out with the required result. If, however, they do not, due to increased intracranial pressure, then if the doctor is not a surgeon he can call the surgeon from the nearest hospital who has a conception of the technique of doing a proper subtemporal decompression. The patient can be quickly transferred and the damage done at that late day can be overcome by a decompression opening made by the surgeon. The patient should be taken immediately to the operating room rather than having a lot of procedures of a mechanical nature to add diagnostic material to the case history.

The only effect of a decompression is to add space for swelling. Also it gives the opportunity of determining if the swelling is due to brain edema or whether it is due to clots, extradural or otherwise. Even a small bur opening with small amount of trauma will give the information desired and will be a knowledge measure as to whether or not a more widespread decompression should be done.

One word of warning in skull fracture cases: When the fracture line extends into the accessory sinuses—and that occurred in the first case where we had a dropping of cerebro-spinal fluid—there is a tremendous hazard as to the subsequent development of meningitis. These wounds seal up within four or five days. I handled one case, that of a man who fell from a telephone pole. He had multiple skull fractures and six weeks after the accident developed meningitis and died.

To briefly summarize I would advise the consideration of a most conservative plan of treatment, and in the actual failure of this manner of treating skull fracture cases, would recommend a subtemporal decompression with only a small bur opening in the beginning as bleeding or hemorrhage often is present on opening the dura. If the patient in spite of this procedure along with hypertonic salt solution continues to show elevation of temperature, the next step is a second decompression. Some patients with head injury have such massive brain pathology that nothing will save them.

Headaches, as one phase of the convalescence, should not last over a period of thirty days. If the headache persists it is the belief that perhaps there is a continuous cerebral contusion of a mechanical nature from a perversion of the blood supply to the lacerated and edematous area of the brain. It is the belief also that hypertonic salt solution will overcome this vicious blood circulation. Also air injection seems to give relief from headache in a great many of these patients.

It is not advisable to reduce pressure with spinal puncture, for spinal puncture may be followed by secondary brain edema. If the patient's condition is so severe as to warrant spinal puncture, then a properly done straight line subtemporal decompression is about the simplest procedure possible and will relieve the pressure from above. And thereafter no spinal puncture will be indicated. Also the sudden lowering of pressure by spinal puncture may very disastrously produce a recurrence of the condition.

Therefore, I suggest that a conservative plan be carried out in contrast to the previous plan of more drastic procedures, surgical, diagnostic and hasty transportation.

CAUSALGIA OR THERMALGIA*

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Quincy.

It is quite obvious, judging from the numerous authors who have published articles on the subject during the past sixteen years, that causalgia, which had its first classical discussion by Doctor Weir Mitchell[1] in 1864, is attracting more and more serious attention of the medical and surgical profession throughout the world.

It seems that Stopford,[2] in 1917, revived an interest in this much debated symptom complex, when he drew the attention of the English speaking world to this intractable type of pain in two very distant parts of the body. It seems that the affection has a predilection for the median and sciatic nerves. However, this affection can invade any nerve as shown by their pathology.

I hesitate to go into more than a review of the fundamental facts and theories presented on this subject for very evident reasons.

Paul Blanchet,[3] in February 1931, informs Mr. Nathan[4] that the authentic literature covering the subject of causalgia reaches from 1813 to 1930 and comprises no fewer than the names of two hundred contributors.

I respectfully acknowledge the classical discussion and presentation of Doctor Byrnes[5] in Tice's Prac. of Med., Vol. IX, p. 255,[6] issued in 1925, from which I have drawn freely in this paper.

Stopford[2] has given a definition of this condition that few writers, since his day, have seen fit to dissent, viz., "The affection may be defined as a nervous disorder, usually the result of injury, characterized by intense pain, hyperesthesia, trophic and vasomotor disturbances, and occurring only in incomplete division of a nerve."

Mr. Nathan,[4] writing in 1931, expresses the cause in this way: "Post-traumatic in origin and its qualifications are the sensation of burning."

Chevaney,[11] in 1931, puts it this way: "Causalgia is a neurosympathetic syndrome appearing after slight injury of a nerve, especially of the median and sciatic nerves."

Etiology: Numerous authors have catalogued the symptoms by which this condition may be recognized. First: The chief subjective group of symptoms seems to be persistent, excruciating, throbbing, bursting pain as if by heat; also drawing, stretching, unrelenting pain and the sensation of heat. Second: The objective symptoms may be described as hyperesthesia of hand or foot—pressure sensations—swelling of affected parts; hyperhidrosis may be present; trophic disturbances may be observed; rarely may the bone or joints be affected. The skin over affected area is sometimes glossy and exquisitely tender, hyperemic or anemic according to whether the vasomotor dilation or the vasomotor constriction is in control.

The implied reasons for this group of distressing symptoms and the pathology found to exist in such cases may be discussed together.

Spurling[7] reports a case in 1929 in which true Raynaud's disease and causalgia co-existed in the same case—hence this affection similating another syndrome.

Stopford[2] observes that anatomically the sciatic and the median nerves carry proportionately a larger number of vasomotor fibers than other nerves, which fibers are required to supply the plantar arch and the palmar arch.

The pathology has *not* been definitely established.

Stopford[2] claims that in injuries of these two particular nerves the lesion is usually above the entrance of the neural vessels.

Kramer and Todd[8] have shown, however, that these vessels receive their innervation at irregular intervals throughout their course from fairly constant nerve trunks.

Lerische[9] suggested that causalgia may be due to injury of the periarterial sympathetic fibers and this opinion has since been supported by the observations of Tinel, Cayla[10] and others.

Nathan,[4] in 1931, states that the cerebrospinal system and the vegetative system are intricately related and one is never sure whether interventions upon the one do not involve the other. He mentions "causalgia zones" and "causalgia fields."

Spurling[7] has observed allochiria, probably referred pain by a cerebral mechanism; that is, when affected part pained, the corresponding part on the opposite side also pained. He reports one patient suffering of ischemic causalgia of the arm due to a gunshot wound of the second portion of the axillary artery, which was successfully treated by dorsal sympathetic ganglionectomy. And concludes that causalgia continues the most troublesome of complexes.

Souques[15] observed a soldier, who sustained a wound in the left median nerve but wore a rubber

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glove on his right hand. Hence the designation the "trigger zone" which may be remote from the true seat of pain or pain zone.

Hyperexcitability of the sympathetic centers with extension of the discharge to neighboring centers, or even to homologous centers of the opposite side of the cord, are thought to account for some of the symptoms and explain the synesthesalgic features of the attack.

Chevaney,[11] writing in 1931, observed the constitutional sympathetic hyperexcitability is indispensable to begin with in producing causalgia. The symptoms are thought to be of reflex origin, and transmitted through the vascular sympathetic fibers or, perhaps, through the sympathetic fibers within the nerve trunk. Precipitation of the attack by emotional states, and the thermic, vasomotor, and trophic changes accompanying the affection, are advanced in support of this contention.

Treatment

Wood,[12] in May 1924, reports a case in a young man who suffered lacerations of the middle finger on his right hand which he later amputated. They did a periarterial sympathectomy of artery with ring of alcohol after Sampson and Handley.[13]

This method has been successful in two cases of senile gangrene and Ford has used it in leg ulcers. The results obtained are thought to be due to interruption of the normal "flow" of vasoconstrictor impulses to the periphery.

In Lerische's[9] method of periarterial sympathectomy the tunica externa is completely stripped from the artery and is followed by the formation of dense adhesions around artery.

In July 1931, Flandin, Pomeau-Delille with Van Bogaert[14] report a case of causalgia resulting from fractured scaphoid bone and found Raynaud's syndrome associated therewith. They say that experiments point to an extravascular origin of causalgia and recommend periarterial sympathectomy for its relief.

Chevaney,[11] in November 1931, reports a case of causalgia resulting from an intravenous administration of calcium chloride to a case of pulmonary tuberculosis and is firm in his opinion that periarterial sympathectomy after Lerische[9] offers most beneficial results.

In the surgical treatment of causalgia, more has been learned of the true pathology, perhaps, than in any other one method of investigation.

Stopford[2] states that partial division of the nerve and intraneural fibrosis are always observed, and the frequency of intraneural hemorrhage in war injuries probably explains the associated fibrosis.

There is found a formation of scar tissue around nerve trunks and their branches—strangled by sclerotic tissue. Perineural fibrosis and fibers of nerve tissue disseminated in scar tissue predominate. Sepsis does not necessarily enter into the conditions found as an etiological factor; however, it may complicate and probably intensify a given case.

Lerische[9] was among the first to suggest denudation and excision of the periarterial sympathetic plexus for the relief of this condition.

Tinel[10] advocates section and immediate suture of the nerve near the termination as the most effective treatment. He says when relief is not obtained by this method the section was performed above the primary lesion.

Injecting the nerve with alcohol was done by Sicard[16] and later Pitres and Marchand, Godlewski, Binot, Morell[17] and others. He recommends this procedure when pain is confined to course of the nerve only.

The nerve is exposed and injected three or four centimeters above the lesion with 60% or 80% alcohol. Failure to relieve the condition occurs when the injection is performed below the lesion or distal to it.

Delorme[18] advocates excision of neuromata and suture of the divided nerve.

Other treatments advocated consists of phenol, ionization, and x-ray with varying success.

It would be well to bear in mind Volkman's contracture, thrombo-angiitis-obliterans before making one's diagnosis.

Case Report

Mrs. L. I. Age 54. White. Irrelevant history, except mild arthritic symptoms over a period of last three years. Sustained accident on August 23, 1933, when her automobile overturned, pinning her left arm between the beam over the window and the ground. Her humerus was crushed at junction of middle and lower third, at same time the tissues composing arm were very seriously traumatized. She received immediate attention and arm was put up in temporary splints amply padded and made adequately comfortable.

On the fifth day after accident it became evident that her arm was suffering from an insufficient blood supply and perhaps consequent gan-

grene. At this time all dressings were removed and soothing lotions alternated with heat applied for a week. At this time it seemed wise and the condition of the arm justified placing it in a loose plaster cast. This was done with the aid of a fluoroscope.

On September 15, 1933, she was removed to her home from the hospital and immediately her distress and suffering began growing more serious—especially in her wrist and her hand and fingers. No cause could be ascertained, other than the primary traumatization.

On September 30, 1933, she was carried back to the hospital for investigation and for a new plaster cast. At this time it was ascertained that her blood chemistry and urine chemistry were within normal limits. The blood serology was negative. Her temperature had never been above normal except a few days immediately following her accident.

After a distressing and alarming period, following the placing of her arm in the second plaster cast, I was forced to remove all the cast and dressing in order to relieve the patient's psychic impressions of the pains being occasioned by the plaster cast. I was forced to adopt the use of opiates, barbiturates, cold tar products, heat, position and persuasion. But with all these she continued to declare that her forearm, wrist and front finger would drive her insane. She described the affected parts as burning her to blisters, overheated, throbbings by paroxysms. She stated that if a weight were hung to her wrist and forefinger it could not feel more distressing. Then the palm would burn to a blister, she asserted. She became so sensitive to tactile phenomena that she would not permit cotton, gauze, soft washed linen to come in contact with hand or arm—she would affirm at times that she could observe swollen areas and feel blisters that were torturing her insane. Only silk would be allowed to come in contact with her arm and skin.

Objectively, one could observe the parts becoming pale at times, but the rule was that the color was normal or red, slightly congested, very glossy, dry and, at times, swollen, slightly just above the elbow joint. There was no trophic disturbances and generally speaking the whole picture looked decidedly encouraging.

At times when the nurse or I happened to contact the arm the patient would scream from pain and frightened apprehension. She declared that the pain was felt as well in her right costal region.

Patient, despite her physical improvement, became quite psychopathic over her pain and the burning agony and hinted at self-destruction if given an opportunity. During this same period she could lift the arm in any desired position, even as high as her head, if not aided. She could bend the elbow joint, move all of her fingers, but expressed discomfort and inability to move her front finger. Supination and pronation within consistent limits was easy to her if it was voluntary on her part, but she would not allow passive motion.

On November 2, 1933, I referred her to a noted neurologic surgeon in a distant city and he in turn called a noted bone man into the case. Her blood chemistry then was consistently normal—her serologic tests remained negative and her urine chemistry was satisfactory. These competent specialists re-x-rayed her and treated the arm symptomatically, not attempting surgical interference, for they agreed that the procedure was not justified.

On December 2, 1933, they sent the patient home improved in only one respect that I could observe, that was psychically. Her pain remained so far as I could judge about the same that it was the month before. However, she had become more reconciled to her pain. Her burning sensation seemed about the same, judging from her description.

On December 27, 1933, the patient, while walking on a rug in the hallway of her home, slipped and fell broadside on her affected arm, which by this time could be carried fairly comfortably in a sling.

The x-ray showed a complete separation of the ends of the bone which was formerly fractured. Within a week from her last fracture she smilingly remarked that she could move her front finger quite as well as the others on the affected side. I did not observe any difference. She also comments that her burning and drawing sensations have been constantly growing less. It is remarkable that she still complains bitterly of neuralgia in her right costal region.

Conclusions and Comment

1. To Dr. Weir Mitchell belongs the distinction of classically describing causalgia in 1864 for the first time.

2. Dr. Paul Blanchet states that authentic literature on causalgia reaches from 1813 to 1930.

3. The author is in complete accord with

Chevaney in attributing this pathologic condition to "a neuro-sympathetic syndrome produced by trauma."

4. Undoubtedly one type of this intractable pain may be relieved by the release of pressure on the nerve or its branches which is involved in the original trauma zone.

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THE DENGUE EPIDEMIC IN MIAMI*

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It had been twelve years since Miami had an epidemic of dengue fever. During that time the population has undergone a radical change, the greater part of its residents coming from parts of the country which have never been visited by this painful malady. Most of the medical practitioners have had only a textbook knowledge of the disease and some, with no little skepticism, were slow in becoming convinced that the cases they were diagnosing by fanciful names were cases of the sickness that at intervals has attacked southern cities with a morbidity rate greater than that of measles and second only to influenza such as we had in 1918.

During the writer's incumbency as Health Officer of Miami, every summer one or more doctors have reported as dengue some case which, upon careful investigation, proved to be something else. One doctor, about four years ago, signed a death certificate giving dengue as the cause of death, and when called upon to give the reason for his diagnosis, replied: "Well, I had to sign an insurance blank and I had to give some cause, so I just put down dengue." To this doctor of slovenly diagnostic habits and others whose diagnoses were honest mistakes, it was pointed out that when dengue arrives you have not an isolated case, but dozens of them, hundreds of them, even thousands, depending upon the size of the community. The first case diagnosed proves more than likely to be the tenth or the fiftieth. The records of the epidemic in Miami twelve years ago are incomplete, but from what these old-timers say, it must have been widespread. In the 1934 epidemic, it is safe to say, Miami has had in the neighborhood of 15,000 cases.

One day in July we heard that somebody's cook had dengue and that a certain negro doctor was treating her. He was immediately called up on the phone and he assured us that it was nothing of the kind, that he knew dengue, and she was suffering with a malady having no symptoms in common with dengue. As he was a reputable physician of some ability his denial was taken at face value. But, alas, after years of hearing the cry of "Wolf, wolf" only to find each alarm a false one, the wolf was at last at our door and not a single doctor detected his presence or raised an alarm.

A few days later, on July 16, Carrie Emanuel, our colored city nurse, reported that there were a number of negroes sick, and upon inquiring as to the symptoms, the realization was borne in upon us that this sickness must be dengue.

The first case seen was another colored city nurse, reported sick that day, and the case proved to be a typical one; furthermore, *Aedes aegypti* mosquitoes were found in the house. Two other cases were found in adjoining houses. The same day, Dr. Frank Davis, City Medical Officer, reported the case of a white man who had a store in colored town. We found him and his daughter with unquestionable symptoms of dengue.

Dr. Henry Hanson, the State Health Officer, was notified immediately, and our entire force of inspectors was thrown into the area to make a house-to-house survey, many mosquito breeding places being found and eliminated. It was clearly evident that already a considerable number of cases had occurred and that the epidemic was under way.

The close proximity of the houses in the colored section, all unscreened, made it possible for the dengue to spread like wildfire. Owing to a lack of funds and personnel, the sanitary oversight of

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colored town had not been very strict and conditions there were bad. Numerous cans, tubs, old tires and other receptacles lying around in yards proved admirable breeding places for mosquitoes and mosquito breeding was at its height owing to heavy rains in June and July.

The next step taken was to notify by phone every Miami physician of the presence of dengue in the community and to urge him to report promptly all cases. A statement was prepared for the newspapers advising the public of the presence of dengue and impressing upon all citizens the importance of cleaning up their premises. There was, as is usually the case, some objection at first upon the part of the city authorities and others to giving publicity to the epidemic on the grounds that it might hurt the city. It was pointed out to them how Chicago had made a fatal mistake last year by failing to take the public into its confidence until the epidemic of amebic dysentery had taken its fearful toll. Acquiescence and cooperation on the part of the city authorities and the public followed and made things easier.

A signed statement was prepared and furnished to the Associated Press, so it never can be said that Miami did not lay all its cards on the table.

About this time Doctors Hanson, Brink and Griffitts of the State Board of Health spent a day in Miami and made a survey of the situation. Knowing that Dr. Hanson would duly warn Florida cities, the writer at the risk of being considered presumptious, wrote to the health officers of Valdosta, Waycross, Brunswick and Savannah suggesting that anti-mosquito work be undertaken.

No effort had ever been made to stamp out a major epidemic of dengue, a conclusion we reached and which was confirmed by Dr. A. F. Mahaffy of the Rockefeller Foundation, who came to secure specimens of dengue blood for experimental purposes. We found we were treading new ground and pioneering in a new field with no precedents to guide us. However, a plan to limit mosquito breeding places was carefully mapped and was followed out in the succeeding weeks.

The FERA was appealed to and Mr. W. H. Green, Regional Director, cutting much red tape, detailed fifty white collar men to work under the Director of Public Health. The city was divided into fifty districts and each placed in charge of an inspector. These workers were instructed to make a house-to-house inspection and were grouped for convenience under eight foremen, who made regular reports and who transmitted orders issuing from our office to the men in the field.

The campaign for the elimination of mosquito breeding places was begun on August 1 and continued steadily for eleven weeks. At the beginning, ten thousand official notices citing the city ordinance against maintaining mosquito breeding places were printed and were served to each home by the garbage collecting crew. The press and the radio were used to elicit cooperation of the citizens in the fight. A campaign along similar lines was carried on by Coral Gables and Miami Beach with effective results.

A detailed report of the work done in this war on the *Aedes aegypti* is here given showing by weeks the number of inspections made, the number of possible breeding places, the number of actual breeding places, the amount of rainfall, and paralleling it, the number of cases officially reported.

Week Ending	Premises Inspected	Possible Breeding Places	Actual Breeding Places	Dengue Cases Reported	Rainfall
July 19				80	2.92
July 26				117	2.61
Aug. 2				80	0.56
Aug. 9	15,310	11,318	11,501	120	0.28
Aug. 16	14,246	13,280	10,033	199	0.88
Aug. 23	15,058	7,563	5,619	161	0.29
Aug. 30	14,786	4,158	2,764	120	1.58
Sept. 6	10,082	3,036	1,923	54	0.94
Sept. 13	13,416	2,991	1,483	92	0.40
Sept. 20	11,639	3,518	1,232	74	7.61
Sept. 27	13,504	3,497	1,231	41	0.31
Oct. 5	13,687	3,375	1,412	25	0.59
Oct. 12	9,973	2,281	774	22	0.55
Oct. 18	7,794	1,581	429	15	...
	139,495	56,598	38,401	1,200	

It is interesting to note that the peak of the epidemic was reached on August 16. This coincides with the completion of the first round of house-to-house inspections by the mosquitc brigade, as it required two weeks for each man to cover his territory. On his visit Dr. Griffitts remarked that when the breeding places had been reduced to ten per cent, the situation might be considered to be well in hand. It required ten weeks to attain this objective, but it was done. Five complete rounds of the city were made between August 1 and October 12, and the number of actual breeding places found and eliminated were as follows: 1st round 21,534; second round 8,383; third round 3,406; fourth round 2,463; fifth round 2,186.

We were notified that the FERA funds would

be discontinued on October 18, so during the last week the emphasis was placed on inspection of the down-town district, hotels, boarding houses, apartments, theaters, churches, assembly halls, stores—in fact, all places where the visitors to the approaching American Legion Convention would be likely to stay or to frequent. A meeting of the Miami Hotel Association was called and Dr. Griffitts addressed them upon the importance of eliminating by spraying or other means all adult mosquitoes from their lobbies, halls and vacant rooms. Cooperation was promised and given to accomplish these ends, a careful check being made on each hotel.

That the entire campaign was successful and our visitors were protected is proven by the fact that although around 50,000 people came to Miami we have yet to hear of a single case of dengue among them. During the week of the convention the number of cases in Miami was at a minimum, while in some other parts of the state the cases reported reached their maximum. The campaign thus successfully carried out made it possible to hold the American Legion Convention. But for it, the convention would have been a miserable failure, or would have been called off altogether. It was no fanciful allusion but a statement of plain truth, that when the fifty inspectors assembled to make their final reports and turn in their badges, they were told: "On next Tuesday when you stand on the sidelines and watch the colorful parade, while thousands cheer, each man of you can hold his head a little higher, stick out his chest and say to himself 'I helped to make this thing possible.' "

In conclusion, certain special features are hereby noted:

1. The origin of the epidemic is obscure. About the time of its beginning, an Associated Press item stated that there was an epidemic of malaria with 25,000 cases in eastern Cuba, and this was interpreted to mean that dengue was referred to. This, however, has not been verified. Of more importance is the fact that the U. S. Public Health Service Weekly Reports carried the item that for the month of June, 1934, there were seventy-two cases of dengue reported in Mississippi. This outbreak would seem to antedate the first Miami case and was probably the source from which the epidemic commenced.

2. Attention is called to the comparatively mild nature of the epidemic. So far as we have been able to determine, no deaths were due to dengue *per se*. The instances in which death was attributed to dengue indicate that it played a contributory part to conditions that would doubtless have proven fatal when complicated with any similar acute febrile condition. Not less than fifty cases were brought to our attention where the parties suffered with dengue twelve years ago. Three instances were reported in which the patient apparently had dengue during this epidemic and a second attack six weeks or more later. While this cannot be vouched for, the cases were reported by reputable physicians and it is deemed worthy of note as the literature on the disease is so scanty. A careful study of one hundred cases treated at Jackson Memorial Hospital has been made and will be published. One or more doctors have made careful clinical notes on their patients and will add their contributions to the literature.

3. New and unsuspected breeding places for the *Aedes aegypti* were discovered by the inspectors. Mosquitoes were found breeding in soft drink bottles, ice cream cartons, conch shells, overflow water from a refrigerator, old boats drawn up on the bank containing rain water. Old automobile tires proved to be one of the commonest breeding places. Fish pools in which the fish had died usually contained larvae. Catch basins were not a problem to us as these have been regularly oiled for nine years past.

4. Dr. W. A. Sawyer of the Rockefeller Foundation writes concerning the results of work done with the specimens of dengue blood taken by Dr. Mahaffy that the tests were essentially negative. The following is quoted from his preliminary report:

"The dengue sera were injected into *Macacus rhesus, M. cynomolgus, Cercopithecus,* and *Cebus* monkeys and also into Guinea pigs, rabbits, white rats and several strains of mice were inoculated intracerebrally, and rabbits were also inoculated intratesticularly. Except for the mice and Guinea pigs, none of these animals showed any reaction. In some instances the mice and Guinea pigs developed symptoms, but when subinoculations were made on the chance that the illness might be due to dengue virus, the symptoms ceased to appear, suggesting that the manifestations were not due to dengue virus. The conclusions of Dr. Wray Lloyd, who did the laboratory work, are that all the animals used were resistant to dengue virus."

5. The epidemic has revealed to us in a startling way a fact that we are prone to forget;

namely, that we are still vulnerable to yellow fever since the *Aedes aegypti* is the vector of both diseases. Had the first case been one of yellow jack instead of dengue, Miami would have had not less than 1,500 fatalities in an equal number of cases, and the widespread distribution in every part of Florida proves that no part of the state is free from the possibility of such an epidemic. The moral is plain: We must continue to wage a relentless war on the domestic pest, the *Aedes aegypti.*

DENGUE IN FLORIDA, 1934, AND ITS SIGNIFICANCE*

T. H. D. Griffitts, M.D.,
Jacksonville.

Since the first recorded epidemics of dengue (Cairo, Egypt and Batavia, Java in 1779, and an epidemic in Philadelphia in 1780, described by Benjamin Rush in 1818), this disease has ever brought to mind the thoughts of its striking similarity to yellow fever. Long before the transmitting agent of yellow fever (*Aedes aegypti*) was definitely known, physicians in various parts of torrid and temperate zones observed and recorded facts concerning the parallel epidemiology of the two diseases. Strangely enough, too, that Linnaeus 18 years before the recorded epidemic in Cairo had found in that part of the world and described the mosquito which we now know as *Aedes aegypti,* and which is a vector—at least the most important vector—of both yellow fever and dengue. Epidemics have occurred at more or less lengthy intervals in various areas between parallels 32°, 47'N. and 23°, 23'S. and even beyond these lines at times. In other words, during favorable seasons of warm and wet summer months with resulting heavy production of *Aedes aegypti,* plus the introduction of a first case or production of the first case through the importation of infected *Aedes aegypti,* limited epidemics have occurred in areas beyond its ordinary boundaries. Examples, Philadelphia, Constantinople, Athens and other points in Greece. The rapidity with which dengue spreads in non-immune populations is probably exceeded only by influenza. The fact that in most epidemics of dengue there is such a relatively large percentage of cases of mild type, many unrecognized and many more not officially reported, lays the foundation for widespread mosquito infection. In any given epidemic ambulatory cases are not only more exposed to bites of mosquitoes in daytime than the bed-ridden cases, but even in the more or less restricted travel of the ambulatory cases they chance to infect mosquitoes over a wider area. This is responsible, then, for the greater rapidity of the spread of dengue than in the case of yellow fever. On the other hand the dreaded mortality from yellow fever incites greater activity in preventive measures, such as prompt and accurate reporting of cases, greater care in protecting not only the sick but the well from mosquito bites, the employment and training of medical and sanitary personnel and the expenditure of funds for epidemiological investigations and vector control.

One frequently hears, even today, that dengue is only a painful disease of short duration; the patient "sick enough to die, but doesn't." This is erroneous. While uncomplicated cases recover from dengue, the same may be said of many other diseases. What difference does it make to the corpse whether death came in one flight or with "stop-over privileges"? Only 10 per cent of yellow fever cases are fatal, the same as from typhoid fever. But in the days when diagnoses of yellow fever were made only when the patient had "black vomit" and died, it is no wonder yellow fever mortality seemed so appalling. And as time goes on and research progresses we are learning more and more about the epidemiology and the endemic characteristics of yellow fever and dengue. Through immunity tests for yellow fever in recent years developed by Sawyer and others we now know that yellow fever in its present endemic areas is not a very deadly disease at this time. But *dengue* from some yet unexplained cause produced a startling mortality during the 1928 epidemic in Greece. Do the viruses of yellow fever and dengue, like smallpox, for example, alternately become more or less virulent, and what is the *modus operandi?*

According to records, the City of Athens, Greece, had approximately 239,000 cases of dengue up to September 4 in the 1928 epidemic. This represented 75 per cent of the population of the city. The registered deaths from all causes in Athens for the month of August, 1928, totaled 1,268, of which 413, or 32.6 per cent, "were certified as due to dengue." In Piraeus, a city of

*Read before the Sixth Annual Meeting of the Florida Public Health Association, Jacksonville, December 3-5, 1934.

136,000, during the same month of August registered deaths from all causes numbered 592, of which 176, or 29.7 per cent "were caused by dengue." So serious was the outlook that Italy and Malta enforced quarantine measures against Greece. By October of that year dengue was introduced into Cairo, Egypt from Greece and a severe epidemic developed. At Cairo an active campaign was waged against *Aedes aegypti* as a major measure in combatting the epidemic. Cairo had previously (1880) suffered from a visitation of the disease to the extent that it was estimated that 80 per cent of the population suffered attacks. In repeated epidemics not only in Southern Europe, Egypt, South America, Central America and the West Indies, but in our southern states, practically all the population in some towns have been victims of the disease.

In 1922 there was something of a pandemic of dengue in the southern states. In that year the first recorded cases were at Tampa, Florida, the disease later spreading to many southern cities and smaller centers. A light prevalence was reported for 1923. Since the latter year there has been comparative freedom from the disease.

On July 16, in 1934, were recorded in Miami the first official reports of dengue. By July 24, 123 cases had been reported and it was estimated by the City Health Officer there had been 292 unreported cases. Up to November 24 the number of cases of dengue reported in Miami was 1,003, with an estimate of over 15,000 cases. In other words, 1 in 5 cases was officially reported. Early in the epidemic, particularly, there was a relatively large number of mild cases among the negro population, which fact contributed not only to the lack of reports, but served to further the epidemic and render its control more difficult. As the epidemic progressed the cases became more nearly typical (as is the history in other epidemics), and it is probable that a larger percentage of cases was reported.

In an effort to limit the spread of dengue from the Miami focus, the Florida State Board of Health, with the cooperation of the U. S. Public Health Service, early began an active publicity, or what is usually designated educational, program. Various population centers were urged to organize and carry on *aegypti control.* The response was generally good, and within a few days many cities were cleaning up *aegypti* breeding containers. So far as serious epidemics are concerned, these efforts, coincident with a rather long continued dry spell, were successful. However, such reports as have been made to the State Board of Health show that dengue appeared in 70 cities, towns and villages in 31 counties. The total number of officially reported cases for the state was 1,671, with Greater Miami having reported 60 per cent of the total. The only other places reporting more than 25 cases each were: Tampa, 157; Orlando, 120; Ft. Lauderdale, 70; Hallandale, 44; and Jacksonville, 35. The following table presents the distribution of cases in the state.

County	Location	Cases
Baker	Glen St. Mary	1
	Sanderson	1
Bay	Lynnhaven	1
	Panama City	22
Bradford	Hampton	1
	New River	1
	Starke	2
Brevard	Cocoa	4
	Titusville	5
	Indian River City	1
Broward	Ft. Lauderdale	70
	Hallandale	44
	Pompano	16
	Dania	8
	Hammondsville	1
	Hollywood	1
	Liberia	16
	Deerfield	2
Charlotte	Punta Gorda	1
Columbia	Lake City	1
Dade	Miami	1003
	near Miami	3
	Miami Beach	4
	Homestead	16
	Coral Gables	16
	Ojus	1
	Everglades	1
	Hialeah	4
	Peters	1
Duval	Jacksonville	35
	Eastport	1
Escambia	Pensacola	3
Hardee	Bowling Green	1
	Zolfo	1
Hernando	Brooksville	1
Hillsborough	Tampa	157
	Port Tampa	1
	Sulphur Springs	2
Indian River	Winter Beach	2
Jefferson	Waukeenah	1
Lake	Groveland	1
	Tavares	1
	Umatilla	1
Lee	Ft. Myers	1

County	Location	Cases
Liberty	Hosford	1
Manatee	Bradenton	1
	Manatee	1
Monroe	Key West	22
	Tavernier	1
Orange	Orlando	120
	Apopka	1
Palm Beach	West Palm Beach	22
	Lake Worth	2
	Delray Beach	1
Pinellas	Clearwater	1
	Palm Harbor	1
	Dunedin	2
	St. Petersburg	2
	Tarpon Springs	4
Polk	Auburndale	2
Putnam	Palatka	3
	Crescent City	3
St. Johns	St. Augustine	3
	Hastings	1
St. Lucie	Ft. Pierre	15
Seminole	Sanford	1
Suwannee	McAlpin	1
Volusia	Daytona Beach	4
Walton	DeFuniak Springs	3

Three deaths (all adults) were reported in Miami. Of interest in connection with the age group distribution of cases, there were five infants under one year of age, and 43 cases among children from 1-5 years old, which is said to have been rare in other epidemics, notably in the Havana epidemic reported by Agramonte.

In the reports which gave the ages of the patients, the distribution was as follows:

	Under 1 year	1-5	6-13	14-17	18-34	35-49	50-69	70-up
No. Cases	5	43	73	23	285	193	115	20
Per Cent	.7%	5.7%	9.6%	3%	37.6%	25.5%	15.2%	2.7%

To some practicing physicians and health officers who have virtually forgotten yellow fever, this prevalence of dengue may well serve as a timely reminder that yellow fever still is endemic in certain areas in South America and in West Africa; that regular direct airplane flights are established between West Africa and Brazil and between Brazil and Miami; that the U. S. Public Health Service has demonstrated that *Aedes aegypti* have been carried for more than three days in airplanes in flight from one country to another. Furthermore no one should cherish the erroneous idea that yellow fever does not exist in this country today because *Aedes aegypti* have been "eradicated" or even "controlled." Every urban community has its array of artificial containers, from flower vases to catch basins producing *Aedes aegypti.* For example, Tampa in six weeks reported 642,392 and Miami in eleven weeks 56,598 containers, potential breeders of *A. aegypti.* While we long assumed that only one mosquito (*Aedes aegypti*) transmitted yellow fever and dengue, it is now known that more than a dozen species are capable of infection with yellow fever in Africa and Brazil, and that at least two species of *Aedes* (*aegypti* and *albopictus*) have been proven infectable with dengue in the Philippines.

As a safeguard all passengers and members of crews of airplanes arriving in Miami and Brownsville from foreign and insular ports are given physical examination upon arrival, and the destruction of mosquitoes on such aircraft has been made mandatory.

The eternal vigilance on the part of the U. S. Public Health Service, through its Foreign and Insular Quarantine Division, is the price of freedom from yellow fever in the future, and in this activity full cooperation of state and local authorities is necessary.

This year's experience with dengue should serve to remind us of the urgent necessity for continuous and efficient *Aedes aegypti* control in all our southern ports. It is not beyond the realm of possibility that a case of yellow fever or an infected *Aedes aegypti* may be imported by air or water traffic so long as the disease continues endemic in areas in South America and in Africa. The wide prevalence of *Aedes aegypti* still constitutes a grave potential danger which must not be tolerated. The cities and towns which have carried on anti-aegypti work in 1934 should actively keep up this work, and all other southern ports should inaugurate similar measures, in order that there may be reduced to the minimum this worst of southern household pests and vector of yellow fever and dengue.

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DUES

It is provided in the By-Laws of the Association (Chapter VIII) that "The secretary of each County Society shall forward its assessment, together with its roster of all officers and members, list of delegates and list of non-affiliated physicians of the county, to the secretary of this Association thirty days in advance of each Annual Session." It is further stipulated that if a society fails to comply with this provision, none of its members or delegates shall be permitted to participate in the business or proceedings of the Association or of the House of Delegates.

It becomes necessary for the Business Office of the Association to close its books, as provided in this By-Law, thirty days in advance of the annual meeting. This means that the dues must be in the Business Office by April 13 of this year.

The Executive Committee has specifically ruled this year that all delegates who are seated in the House of Delegates at the annual meeting must be members in good standing. It is urged that the officers of each component county society stress to their members the importance of paying their dues promptly in order that a full representation of each society may be had at the meeting of the House of Delegates.

The By-Laws further state that representation in the House of Delegates is based upon the paid membership of each component society. For each twenty paid members, or major fraction thereof, one delegate is seated from each county medical society.

POST-GRADUATE SHORT COURSE

The schedule for the third annual Graduate Short Course for Doctors of Medicine in Florida, to be held in Gainesville, June 24-29, has been completed. In the opinion of the committee on arrangements, it is the strongest possible course for those men in the state who desire review in the major branches of medicine.

Dr. Horton Casparis, Professor of Pediatrics at Vanderbilt University, who presented the course in pediatrics last summer, has consented to return for this year's session. The lectures in general medicine will be presented by Dr. Oscar W. Bethea, Professor of Clinical Medicine at Tulane University. Dr. Fred Lyman Adair, Professor of Obstetrics and Gynecology at the University of Chicago, will give the lectures in obstetrics. The course in gynecology is to be given by Dr. Emil Novak, Associate Professor of Obstetrics at the University of Maryland. Dr. Arthur M. Shipley, Professor of Surgery at the University of Maryland and Associate Professor of Surgery at Johns Hopkins University, will offer the course in general surgery, while the lectures on orthopedic surgery will be given by Dr. Willis Campbell, Professor of Orthopedic Surgery at the University of Tennessee. The teacher for the course in venereal diseases is to be selected by the United States Public Health Service, and will be announced later.

The week's activities will be outlined in detail in the next issue of the *Journal*.

PRE-CONVENTION MEETING

The annual pre-convention meeting of the Florida Medical Association was held in Orlando, on February 7th, 1935. It was the exceptional privilege of the Association to be honored by the presence of the President of the American Medical Association, Dr. W. L. Bierring.

The various state committees met in the morning and early afternoon and formulated plans and recommendations to be presented at the state meeting in Ocala. The councilors met at 1:00 p. m., at which time a buffet luncheon was served, followed by a reading of the reports from the various districts by the chairman, Dr. Clifton Moor.

The formal session of the meeting was called to order by Dr. Pearson, the president, at 5:00 p. m. The reports of the various committees were given by each chairman and in turn discussed and prepared for presentation at the annual meeting of the Association at Ocala in May.

At 6:00 p. m. Dr. Bierring was introduced and enthusiastically greeted by a gathering of nearly 200 physicians and laymen who came to hear his most important message. The first part of Dr. Bierring's address was illustrated by interesting motion pictures which disclosed the machinery of operation of the American Medical Association from the printing of the various Journals and publications to the actual office procedures of the executives of the Association. Particular emphasis was placed upon the enormity of the organization and the tremendous size of the plant necessary to carry on the functioning of our national body.

The agenda of Dr. Bierring's address was given over to a frank discussion of the various measures about to be presented to Congress as a part of the so-called Social Security Program. In that Dr. Bierring had only recently been in Washington in conference with President Roosevelt, the information he offered was of first hand importance. All of this proposed legislation, he stated, would be discussed in a called meeting of the House of Delegates of the American Medical Association in Chicago in the near future and some definite course and plan of action decided upon.

At the conclusion of Dr. Bierring's address the meeting adjourned to the University Club, where an informal reception was held followed by a buffet supper.

REPORTS OF DISTRICT COUNCILORS*

SECOND DISTRICT—

F. Clifton Moor, M.D.....*Tallahassee*
Liberty, Gadsden, Jefferson, Wakulla, Leon, Franklin.

The Second District covers the counties of Jefferson, Leon, Gadsden, Wakulla, Liberty and Franklin, and the only county society in the district includes all of these counties.

Liberty and Wakulla Counties have no settlements of more than a few hundred population and only three physicians.

In past years there have been one or more members from Franklin and Wakulla counties, but the distances make it very inconvenient for the physicians from Carrabelle and Apalachicola to attend meetings, and at present none of the men from Franklin, Wakulla, or Liberty are affiliated with the local society.

The society meets quarterly, once in Monticello, Tallahassee, Quincy and Chattahoochee during each calendar year. Meetings have been regular, well attended and with scientific programs of more than average interest. Visitors from adjoining south Georgia cities have made up about half of our attendance and have added to the scientific interest, both by the presentation of papers and by taking an active part in the discussions.

There are 43 qualified physicians living in the district. Five of these are with the Rockefeller Foundation, one a teacher of Hygiene at the Florida State College for Women, eleven are in small rural communities and eight are on the staff of the Florida State Hospital for the Insane. The personnel of the Rockefeller laboratories is constantly shifting and membership in the society is small from this group, and from the physicians in the villages, although for several years there has been a special campaign carried on by the councilor and the officers and members of the society to interest the rural doctor.

THIRD DISTRICT—Thomas H. Bates, M.D., *Lake City*

Hamilton, Dixie, Taylor, Madison, Columbia, Suwannee, Lafayette.

Your councilor for the Third District has to report that three of the seven counties in the district maintain organizations, Columbia, Madison and Taylor. Of these, Columbia County Medical Society had the honor of being the first county society in the state to be 100 per cent in payment of dues for 1935. Incidentally, it has as members every eligible man in the county save one. The members of the staff of the Veterans' Hospital are not sought as members as it has been found to be more satisfactory otherwise. The Taylor County Medical Society includes as members every physician in the county. The secretary told me last night that the dues for 1935 would be forwarded within the next few days. Madison County Society is practically a paper organization; however, several new men have moved in and a revival of interest is under way. Of the other counties little can be expected since they are sparsely settled and are served by so few physicians. Dixie county has three physicians; Lafayette, two; Hamilton, four, and Suwannee, eight, most of whom have at some time belonged to the State Association.

The independent district organization known as the Suwannee River Medical Association serves as a common meeting ground for the ex-

*Read before the Pre-Convention Meeting, Orlando, February 7, 1935.

change of medical thought and the development of fellowship among the men from the various communities in the area and for the introduction of guest speakers from the more populous areas. A spirit of cordiality and cooperation has been built up throughout the district. The economic situation has left its mark upon the physicians and I find a certain amount of dissatisfaction on account of the relations existing and the regulations promulgated by the F.E.R.A. The physicians have continued as always to care for deserving charity cases and in addition have been asked to accept for a shamefully low fee work that they would not otherwise undertake.

FOURTH DISTRICT—

EDWIN C. SWIFT, M.D.....*Jacksonville*
Nassau, Clay, Duval, St. Johns.

During the past year St. Johns County Medical Society reports an increase in their ranks of three new members by transfer from other societies, with loss of one by transfer, net gain two members. In this society there has been no state-wide program of any kind carried out or endorsed, except the adoption of a resolution relative to the care of the mentally ill.

Duval county reports an increase of eleven members, loss by transfer one member and loss by death two members. In this society there has been no state-wide program of any kind carried out or endorsed, except the adoption of a resolution relative to the care of the mentally ill.

At the present time the Duval County Medical Society has members in Clay and Nassau counties, including two physicians in the former and one in the latter. There are five physicians in these outlying counties who have been approached for membership and have declined, due to the fact that they lived so far from Jacksonville that they felt that they could not attend our meetings often enough to benefit from them. There are no eligible, desirable practicing physicians in Duval county who are not members of the Duval County Medical Society.

The objectives of the Duval County Medical Society were: First, to improve the quality of the programs to such an extent that all members would benefit in some way from them. This was carried out admirably in the form of having symposia presented by three or more members of the society on various subjects. Second, the formation of an active economic committee to investigate and ward off the dangers of governmental or commercialized practice of medicine. This committee has worked hand in hand with the Federal Relief Advisory Committee and at the present time is making every effort to maintain the family physician's status in the handling of the Federal cases. In addition all forms of medical and hospital insurance have been investigated and tabulated in order that we may be thoroughly acquainted with any attempt to organize such a scheme in our community.

Recently as a result of an application from a man who is under contract with one of our local hospitals to split his *net* revenue with the hospital, thus insuring them a profit from his services, the society adopted a resolution in conformity to a resolution recently adopted by the American Medical Association, the substance of which is as follows: "The Duval County Medical Society will not consider any one eligible for membership who associates himself with any lay organization, group, hospital or otherwise, which organization shall profit directly from such association."

SIXTH DISTRICT—

LINWOOD M. GABLE, M.D.....*St. Petersburg*
Pinellas.

The Pinellas County Medical Society alone comprises the Sixth District.

This organization holds meetings the first Friday in each month, October to May, both inclusive. One or two meetings each year are held in the upper part of the county, the remainder in St. Petersburg where reside the greater portion of the membership.

The organization has 79 active members and on this date 49 have paid their 1935 dues. Eleven doctors on the staff of the Veterans Hospital, located adjacent to St. Petersburg, are carried as "guest members"—a courtesy designation. These physicians are not licensed to practice in Florida, consequently are not eligible to active membership. It is believed that every physician in the county who is eligible and acceptable enjoys membership. During the tourist season many visiting doctors are guests at the meetings and frequently participate in the scientific sessions. The attendance at each meeting is from 30 to 60 doctors.

The community is overrun with irregular practitioners but the Pinellas County Medical Society finds itself powerless to accomplish their disbarment until the practice laws of the state shall have been corrected. The greatest offenders are the Naturopaths who are prescribing drugs—who

are even granted narcotic licenses by the Federal authorities. Your councilor conveys the unanimous wish of the Pinellas County Medical Society in urging that the Florida Medical Association as a unit and its individual members lend every aid to the Legislative Committee in its present campaign to secure a decent Practice Law.

SEVENTH DISTRICT—

THOMAS C. KENASTON, M.D.....*Cocoa*
Brevard, Volusia, Seminole.

As councilor for the Seventh District of the Florida Medical Association, which comprises the counties of Brevard, Volusia and Seminole, I beg to submit the following report:

Brevard county has an active society with regular meetings held once each month. Doctor L. K. Hicks of Melbourne is the 1935 president and Dr. Robert Schlernitzauer of Rockledge is the secretary. The society has continued its practice of publishing a directory in each of the papers of the county. This directory lists each member of the society and his address. The dentists of the county are invited to meet with the society at regular intervals during the year and programs are arranged to be of interest to this allied profession. There are eleven members of this county society and there are three non-members, of which one or more may not be eligible.

The Seminole County Medical Society has a membership of 10. The president is Dr. C. L. Park, the secretary Dr. J. T. Denton. There are four physicians in the county who are non-members, of which one or more may not be eligible.

There were twelve meetings held during 1934 with an average attendance of 7. During the year 1935 the society will hold meetings on the second Monday nights during January, March, June, October, November and December, thus allowing the other months for visitation of other societies and for vacations.

Dr. G. A. Davis of DeLand is the president of the Volusia County Medical Society. Dr. Hugh West is the secretary. There is a membership in this society of thirty-eight and the 1934 dues were paid 100%.

Meetings of the society are held on the second Tuesday of each month. Much attention is given during the regular meetings to the consideration of the economic situation as it now stands. One of the main issues is trying to stem the tide of Socialistic Medicine.

There are six non-members in the county who are eligible for membership.

EIGHTH DISTRICT—

JAMES H. COLSON, M.D.....*Gainesville*
Putnam, Levy, Baker, Bradford, Union, Flagler, Alachua, Gilchrist.

For the last three or four months I have been in ill health and not able to visit the respective societies of the Eighth Councilor District. I am much better now than I have been since early last Fall, and hope to be more active and have the opportunity of meeting with the respective societies within the district.

As far as I know, there are only two medical societies in this district, which comprise the counties of Putnam, Levy, Baker, Bradford, Union, Alachua, Flagler and Gilchrist. The Alachua Medical Society has a membership of nineteen, and for the year 1934 their dues were paid one hundred per cent. I shall endeavor to interest the members of the society of this district to the extent that we can have a paid-up membership of one hundred per cent for the year 1935. I shall urge the members to have their dues paid up before the Florida State Medical Association meets.

My information is that the Alachua County Medical Society has not taken in any new members during 1934 and 1935, thus far. As far as I know, there are no illegal practitioners engaged in the practice of medicine in this district.

We have an active Ladies' Auxiliary, Mrs. J. E. Maines, Jr., President, of the Alachua County Medical Society, which meets monthly, endeavoring to stimulate interest among members of the medical profession.

I called Dr. E. W. Warren, of Palatka, on the phone and ascertained from him that the Putnam County Medical Society was practically dead. If I mistake not, he told me that they had only four members that paid their dues last year. I shall endeavor to go to Palatka and meet with this society, if it is possible to get them together, and see if I cannot stimulate some interest among them. It occurs to me that it is a reflection on the doctors comprising the membership of that society that they do not manifest more interest than they have in the past.

During the year 1934 radio addresses were made by different members of the profession

under the auspices of the Florida Medical Association. That policy is still being carried out, and regular broadcasts are being made monthly over station WRUF, Gainesville.

There are no existing conflicts, as far as I know, between members of the societies. All members seem to be friendly and working in harmony with each other.

I am sorry to advise that there are a number of physicians in the district who are not members of any county medical society.

I have had an opportunity to contact but few members of the ensuing Legislature with reference to legislation affecting the medical profession.

A committee has been appointed with reference to the location of a state tubercular hospital. So far, they have not designated any town or community where the hospital should be located. It is my information that the Board, in Tallahassee, does not favor establishing a new location for the treatment of tubercular subjects; however, they are in favor of locating such a hospital at some state institution. Their reason for locating the tubercular hospital at some one of the state institutions is because less overhead expense would be incurred. Gainesville, as I understand it, is one of the locations they are considering. We have plenty of land in the tract that goes with the Florida Farm Colony, and in my opinion, that would be an excellent location for the establishment of the institution.

THIRTEENTH DISTRICT—

E. S. GILMER, M.D.....*Tampa*
Hillsboro.

During the past year the membership of the Hillsboro County Medical Society was increased by sixty-two, thirty-four being reinstatements and twenty-eight being new members. At the end of 1934, the total membership was one hundred fourteen. I don't believe there are more than one or two non-members in this district who are eligible for membership. We reported one hundred per cent paid-up membership dues at the last meeting of the State Association.

We had very good scientific programs during the year, including quite a number of scientific contributions from visiting physicians. We had a symposium on cancer which was well attended. At the November meeting, a very excellent and interesting program was put on for us by the Pinellas County Society.

We are still taking care of the medical work for the Transient Bureau and two of our members are receiving a salary for this work, on part time basis. We also arranged, last fall, with the F.E.R.A. to take care of their medical service, in which nine of our members are employed, part time, on a rotating service at $150 a month each. There are also three negro physicians on a salary of $100 a month each. In addition to that, we have twelve men in Tampa and six in Plant City rotating in obstetrical work. At the meeting with the F.E.R.A. representative in Ocala last December there was an arrangement made whereby special work would be paid for on a basis of fifty per cent of the ordinary fee. Arrangements have been recently made by the Dental Society in Tampa to take care of the Dental work at the F.E.R.A. clinic.

At the beginning of the school year last September at the University of Tampa, the Hillsboro County Medical Society gave scholarships to two students who are sons of two of our deceased members.

Saint Joseph's Hospital was opened a few months ago in Tampa. This is an excellent institution operated by a Catholic order, and most of the members of the society were invited to become members of the staff.

On the whole, I believe the membership is in better condition than it has been since the beginning of the depression. Harmony seems to prevail. The question of benefit societies is still a thorn in the flesh.

FIFTEENTH DISTRICT—

H. J. PEAVY, M.D.....*Fort Lauderdale*
Palm Beach, Broward.

There is a plan to have the two societies of this district meet together once yearly. Broward County Medical Society hopes to entertain Palm Beach County Medical Society sometime before the State Association meets.

During the past year there has been increased interest in organized medicine in this district. Attendance at meetings has been larger and more regular. Both societies report an increase in membership. Palm Beach county reports two new members, Dr. Charles Boynton and Dr. James R. Sory.

Officers of the Palm Beach County Medical Society for the coming year are:

President—Dr. W. W. George.

Vice-President—Dr. L. M. Rozier.

Secretary—Dr. Lloyd J. Netto.
Treasurer—Dr. Fred K. Herpel.

A symposium on cancer was held during the past year and was very well attended.

Broward County Medical Society reports the addition of five new members: Dr. Frank Denniston, Dr. L. B. Elliston, Dr. R. L. Elliston, Dr. C. H. Sory, Dr. G. P. Hammer. The first four members are from Fort Lauderdale and the latter from Hollywood. Officers for the Broward County Medical Society for the coming year are:
President—Dr. O. C. Brown.
Vice-President—Dr. R. H. Lingeman.
Sec'y and Treasurer—Dr. R. E. Blount.

Dr. B. F. Butler, chairman of mosquito control work in Broward county has been most active in the past year and this work is well organized and under way.

As a whole there is a greater spirit of cooperation among the physicians of this district and we believe there will be a larger attendance and more active interest in the State Meeting at Ocala this year.

SIXTEENTH DISTRICT—
W. L. Ashton, M.D.....*Umatilla*
Sumter, Lake.

The Sixteenth District consists of Lake and Sumter counties, each having a well organized society.

Sumter County Medical Society's membership while limited in number to four, is maintaining an active interest in organized medicine. Regular meetings are held by the group, together with joint meetings with adjacent county societies and the Central Florida Society. Three physicians residing in the county hold membership in adjacent county societies by reason of accessibility.

Lake County Society continues to function in an aggressive manner. Its membership totals nineteen, and includes all the eligible physicians in the county, three new members having been added to the membership roster during the past year.

Monthly meetings are well attended and programs have been of increasing interest with splendid papers by members and frequent guest speakers. The society has been quite active in promoting adequate hospital facilities and during the past two years two modern institutions providing hospital beds numbering sixty, have come into existence. Well organized staffs from the membership of the society serve these hospitals and this organization is to be commended for its endeavors.

Cooperation among the physicians in the district is all that could be desired, and much interest is manifest in State Association affairs.

SEVENTEENTH DISTRICT—
Louis Orr, M.D.....*Orlando*
Osceola, Orange.

It is with the deepest regret that it becomes my duty to render the report of the councilor for the Seventeenth District in the place of Dr. Gaston H. Edwards. As a past President of the Florida State Medical Association; as sometime holder of most of the important committee positions in the State organization, and, this year, as Chairman of the board of councilors Dr. Edwards expressed his enthusiasm for those things which were for the betterment and advancement of scientific medicine. His interest and genial fellowship is deeply missed.

The Seventeenth District, composed of the counties of Osceola and Orange, has as its single medical unit the Orange County Medical Society. In the past year greater advancement in activity and membership has been made than at any other time during its history. By increasing the society membership to fifty-three, another delegate, making a total of three, has been gained for representation at the State Association.

The society has sought in every way to broaden its lay activities. The Boy Scouts were assisted in the maintenance of their annual summer camp, not only by voluntary medical service on the part of the society members, but by the donation of funds for repairing the premises.

A very firm and definite stand has been taken this year against the continued offering of free medical services to the laity as a group. It is felt that the burden is becoming far too heavy for organized medicine to carry.

The request of the Parent-Teachers' Association this year for free medical service for the pre-school clinics was refused by the society. A counter proposal was offered to the Parent-Teachers' Association to the effect that children would be seen at the office of their family physician for the flat rate of $2.00 and that physicians would offer their services for clinic work for $5.00 an hour. The society agreed to further assist the Parent-Teachers' Association by appearing before the local school board to request that the annual appropriation of funds cover the cost of the pre-school clinics and thus settle a problem which has been a source of annual difficulties to the society.

Revived interest has been manifested, in co-operation with other societies, to institute an active campaign for suitable legislation to control the cults. The participation of the cults in the benefits of the F.E.R.A. medical relief funds of this district was prevented by opposition of the society.

As much pressure as possible was brought to bear upon the political powers in Tallahassee for the appointment of a physician as superintendent of the State Hospital for the Insane.

Dr. Claxton, of the State Department of Health, was encouraged to hold his annual clinic on Tuberculosis in this district; Dr. Edwards was active in the effort to secure the necessary appropriations for carrying on the program of giving children with positive tuberculin reaction the benefits of x-ray diagnosis.

The annual summer picnic of the Orange County Medical Society was held in Orlando June 29th and was attended by several men from the state at large. Many of the officers of the State Association and a number of the councilors were present and, it is hoped, enjoyed the occasion.

The most outstanding activity of the society in the past year has been the continuation of radio broadcasting for the benefit of the laity. For six years the members have prepared original articles on timely health topics or have read those prepared by the A. M. A. The articles have been broadcast through the courtesy of station WDBO. This station allows no broadcasting of medical information except by representatives of organized medicine. Under the chairmanship of Dr. Spiers, the society has recently launched a new series of talks under the general heading of "The Doctor Throughout the Ages," which deals principally with the historical aspects of medical science. This series will be concluded in May, 1935. No doubt, many of these papers will be broadcast for the State Association over the Gainesville station.

EIGHTEENTH DISTRICT—

TOLIVER M. MCDUFFEE, M.D.....*Manatee*
Manatee, Sarasota.

I, as councilor for Manatee and Sarasota counties, beg to report that the medical fraternity here is in first-class condition. We have not missed a meeting. The scientific programs have been very interesting and instructive. We have had several visiting essayists which were enjoyed by all. There has been no dissension in either society.

I wish to thank the President for my appointment. I consider it a great honor to represent two such societies as Manatee and Sarasota counties.

NINETEENTH DISTRICT—

JOHN A. SIMMONS, M.D.....*Arcadia*
DeSoto, Hardee, Highlands.

I herewith submit my report as councilor of the Nineteenth District comprising the counties of DeSoto, Hardee and Highlands.

In view of the fact that these counties are small, and therefore, the number of physicians limited, we have combined the three counties into one organization, viz.: The DeSoto-Hardee-Highlands County Medical Society.

We hold a regular monthly meeting on the second Tuesday night of each month. These meetings are held in different towns throughout the three counties, arranging our meetings alphabetically according to the names of the different towns. We have a dinner at each meeting; and always have a fair attendance. Immediately following the dinner, we have a scientific program, usually provided by one of our members and an invited guest.

Every physician in the three counties, except two, are members of our society, and in good standing. One of these physicians is not in very active practice, in poor health, and therefore, not able physically to attend the meetings. The other was expelled a few years ago for unprofessional conduct.

There is no strife among our members; we are all getting along as one big harmonious family.

TWENTY-FIRST DISTRICT—

L. L. WHIDDON, M.D.....*Fort Pierce*
St. Lucie, Okeechobee, Indian River, Martin.

The Four County Medical Society, including Indian River, Martin, Okeechobee and St. Lucie counties, has at present a membership of eleven. The officers are:

President—Dr. G. L. Harrell, Vero Beach.
Vice-President—Dr. J. D. Parker, Stuart.
Sec'y-Treasurer—Dr. C. L. Davis, Okeechobee.
Delegate—Dr. M. D. Council, Fort Pierce.
Alternate—Dr. E. B. Hardee, Vero Beach.

Our society meets every fourth Thursday, except July and August. There have been no irregularities among the members of the profession. There is one eligible man who has applied for membership, but has not been accepted yet.

EXPLANATION OF PROPOSED MEDICAL BILLS

We feel very much gratified on checking over the reports received from our co-workers and the members of both Houses of the Legislature. We have heard from fifty of our lawmakers with only two unfavorable replies. While this is encouraging, we have but a limited time and must not overlook the fact that all of our laws are made at home and not in Tallahassee. I urge you to not let up but to work harder than ever.

Possibly a little explanation of our proposed bills would not be amiss and would save much time in reading.

The Bill designated as "A" definitely defines the practice of medicine. It does not take away from other members of the healing arts any of their rights and privileges but absolutely limits them to the definition of their own particular acts, thus making more specific the apparent intent of the original Act. Furthermore, it makes provisions for the enforcement of this Act.

Bill entitled "B" states definitely upon whom the duty falls to enforce Act "A", designating the State Board of Health, the State Board of Medical Examiners, every peace officer, including sheriffs, constables, their deputies, police officers and prosecuting attorneys. Thus, violations of the Act will be more closely watched as there are many who are chargeable with its enforcement.

"C". This is an amendment to the Narcotic Act and definitely states who shall be the recipients of the narcotic licenses.

"D". This Act is for the purpose of defining the word "physician" as one who is licensed to practice medicine by the State Board of Medical Examiners with no exceptions unless otherwise designated. It is for the purpose of changing the Florida code so that the Federal agents will be intelligently informed as to whom should be issued narcotic licenses, thereby eliminating all except the regular physicians and osteopathic physicians from prescribing and administering narcotics.

"E", "F", "G". These Bills have to do with the repealing of the annual registration laws and make provisions for the re-registration of applicants licensed to practice medicine. Instead of the classification "G", we are substituting "E" and "F", which will entirely repeal the annual registration Act but make provision for the registration with the State Board of Health of those recently licensed to practice medicine, osteopathy, chiropractic and naturopathy, thereby eliminating chiropody and midwives altogether.

"H" definitely states who are prohibited from prescribing drugs, doing surgery, x-ray diathermy, electro-coagulation, radiation, autohemic therapy, etc., and is self-explanatory.

"I". This Bill, designated as a lien law, has caused more confusion with the members of the legal profession than any other of the Bills. One member of that profession stated that it would cause a good deal of unnecessary litigation, very much to our surprise. However, the majority of them are very enthusiastic about this Bill as it will protect the physicians and small hospitals. This Bill is rather lengthy but every precaution has been taken in drafting it so as to protect the profession and the hospitals. It is possible that it will need some revision before presentation.

The members of the profession have cooperated with me wonderfully. Without their help, we can do nothing but if you men will keep on trying, I believe we will have smooth sailing.

(Signed) J. C. Davis, M.D.,
Chairman Committee on Legislation
and Public Policy.

STATE NEWS ITEMS

Dr. Homer Pearson, of Miami, President of the Association, visited several county medical societies during the month of February. He attended a luncheon meeting of the Polk County Medical Society on February 8 and a meeting of the Hillsboro County Medical Society the evening of the same day. On Saturday, February 9, he was a guest of the Manatee County Medical Society at a luncheon meeting and that evening he addressed the Pinellas County Medical Society. On February 19, he attended a meeting of the DeSoto-Hardee-Highlands County Medical Society which was held at Wauchula. Dr. Pearson reports that the work being done in the component societies is progressing very satisfactorily.

* * *

Dr. and Mrs. J. H. Pound of Chattahoochee announce the birth of a daughter, Alice Gay, on February 15.

* * *

Dr. Charles E. Boynton, Jr., formerly of Atlanta, has opened offices at 305 Harvey Building, West Palm Beach. Dr. Boynton's practice will be limited to pediatrics.

Dr. Eugene G. Peek of Ocala was recently elected president of the Marion County Chamber of Commerce. Dr. Peek was president of the organization some years ago.

* * *

Dr. William G. Doern of DeLand is at present engaged in cancer research work at the Doern Clinic, Milwaukee, Wisconsin.

* * *

The fifth annual meeting of the Florida Society of Dermatology and Syphilology was held in the county court house clinic quarters, Miami, February 24, 1935.

Those in attendance were: Drs. J. L. Kirby-Smith, Frank Wilson and Alan Brown of Jacksonville; Drs. C. A. Andrews and J. J. Saxton of Tampa; Drs. Elmo D. French and Wiley Sams of Miami.

Visitors present who participated in the discussions were Dr. G. N. MacDonell, City Health Officer of Miami, Dr. S. W. Becker of Chicago, and Dr. Rothwell Lefholtz of Miami.

Twenty unusual and interesting cases were presented for examination and discussion. Sections were presented with many of the cases. A very interesting expression of opinions and observations was exchanged.

Dr. Elmo D. French of Miami is chairman of the society and Dr. J. J. Saxton of Tampa is secretary.

LABORATORY TECHNICIAN desires Florida connection. B. S. Degree from Florida State College for Women. Laboratory training from Watt's Hospital, Durham, N. C. References will be furnished. At present employed but wish to make change because of father's ill health. Write Lois E. Wolcott, 510 Masonic Temple, Danville, Va.

COMPONENT COUNTY SOCIETIES

DADE COUNTY MEDICAL SOCIETY

At the meeting of the Dade County Medical Society held in the Huntington Club Rooms, Miami, March 1, the following program was presented:

"Endometriosis", Dr. M. C. Wilson.

"Dengue", Dr. Stewart L. Jeffrey.

An especially called meeting of the Dade County Medical Society was held on February 12. The guest speakers of the evening were: Dr. David Berlin, visiting surgeon of the Boston City Hospital and surgeon in charge of the Thyroid Clinic of the Beth Israel Hospital, Boston; Dr. Charles E. Riggs, former surgeon-general for the United States Navy; Dr. Max Cutler of Chicago; Dr. Thomas A. Groover of Washington, D. C., president of the College of Radiologists. Dr. Homer Pearson of Miami also spoke, in his inimitable manner, on the work being done by the various county medical societies which he had visited as president of the Florida Medical Association.

DUVAL COUNTY MEDICAL SOCIETY

At the meeting of the Duval County Medical Society, held March 5 at the Mayflower Hotel, Jacksonville, the following symposium on syphilis was presented:

"From a Genito-urinary Standpoint", B. F. Woolsey.

"From a Dermatological Standpoint", Alan Brown.

"From the Pathologist's Standpoint", Lucien Y. Dyrenforth.

"From the Standpoint of the Internist", W. W. Kirk.

"From the Neurological Standpoint", J. H. Randolph.

Dr. Henry Hanson then read a paper on "A Survey of the Maternal Mortality in Florida."

MARION COUNTY MEDICAL SOCIETY

THE MARION COUNTY MEDICAL SOCIETY HAS BECOME 100% PAID FOR THE YEAR 1935. THIS SOCIETY IS WORKING HARD IN PREPARATION FOR THE ENTERTAINMENT OF THE ASSOCIATION'S ANNUAL CONVENTION TO BE HELD IN OCALA IN MAY.

WALTON-OKALOOSA COUNTY MEDICAL SOCIETY

THE WALTON-OKALOOSA COUNTY MEDICAL SOCIETY HAS REPORTED 100% OF MEMBERSHIP DUES FOR THE YEAR 1935. THIS BECOMES THE THIRD SOCIETY TO "GO OVER THE TOP" FOR THE CURRENT YEAR.

The following officers have been elected to serve the Walton-Okaloosa County Medical Society for 1935:

President—E. L. Huggins, Freeport.

Vice-President—R. B. Spires, DeFuniak Springs.

Sec'y-Treasurer—A. G. Williams, Lakewood.

Delegate to State Convention—A. G. Williams.

Alternate Delegate—R. B. Spires.

WOMAN'S AUXILIARY

TO THE
FLORIDA MEDICAL ASSOCIATION, INC.

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MRS. S. M. COPELAND
1356 Willowbranch Ave.,
Jacksonville, Florida

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POLK COUNTY AUXILIARY

Mrs. E. R. McMurray of Bartow, state president of the Auxiliary, made an interesting talk before the Women's Auxiliary to the Polk County Medical Society Friday at the Hotel Lakeland Terrace, impressing upon the group the responsibility of each member in making the Auxiliary a helpful factor in the county, as well as a social organization. She urged all members to attend the state medical meeting in Ocala in May.

Following an enjoyable luncheon, a business meeting was held with Mrs. James R. Boulware, Jr., presiding in the absence of Mrs. G. C. Overstreet.

Among other things of interest in Mrs. McMurray's talk was an appeal to each community to plan for a cancer control program. There should be at least three held in Polk county, she stated. The slides and a lecture given by an experienced doctor explain the subject and make a very helpful program, she explained.

Health certificates for nurse-maids in homes was also stressed and members were urged to put the matter before the Parent-Teacher Association of the county.

Members were given the opportunity to pay dues or send them to Mrs. V. H. Ragsdale, Pierce, in the future.

Mrs. Walter A. Weed, the new state secretary and treasurer, made a short talk about her work.

The election of officers will take place at the next meeting, and a nominating committee was appointed as follows: Mrs. S. F. Smith, Mrs. W. A. Weed, and Mrs. J. W. Vaughn.



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Mrs. Joe M. Bosworth was welcomed as a new member.

Volusia County Auxiliary

The Woman's Auxiliary to the Volusia County Medical Society met in January in DeLand and had dinner with the men at the College Arms Hotel. On February 2nd, the Auxiliary furnished a cancer education program for the Volusia County Federation of Woman's Clubs which met in Ormond. Dr. J. Ralston Wells, as member of the cancer control committee of the Florida Medical Association, gave the talk.

The Auxiliary felt honored in having as guest speaker, Dr. J. W. Cox, southern representative of the American Society for the Control of Cancer, who talked on the general subject of cancer prevention and the efforts of his society.

The next meeting will be held in New Smyrna.

* * *

Since there is a scarcity of news from our own state as this article goes to press, we would have you gain inspiration from the semi-annual report made by our sister State Auxiliary of Georgia, and we commend them for their energy and live organization.

"At the end of six months of this administration, the State Auxiliary reports briefly: contacts made with all organizations engaged in health and public welfare work in Georgia; letters sent to presidents of all P. T. A.'s, to district club presidents and to their health chairman explaining our educational work, asking co-operation, offering our material. Five hundred '*Our Objectives*' sent to Georgia Auxiliary members. All state chairmen have sent letters of explanation and recommendations to their county and district committees, 15,000 three-minute talks have been mimeographed and 20,000 on maternal welfare. The Cancer Commission of the Medical Association of Georgia has given the Auxiliary 20,000 pamphlets on cancer. County Auxiliaries are busy forwarding the state programs, and in assisting in Red Cross, Tuberculosis Association work. Our State President, Mrs. J. E. Penland is on the Executive Board of the new Child Welfare Council of Georgia and has appointed Auxiliary chairmen in each county organized. Each State Chairman is actively engaged in studying and promoting her particular work.

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—Proc. Soc. Exp. Biol. and Med., 1934, **32**, 241-245.

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"The Ware County Auxiliary has arranged for physicians to speak on 'Mother Welfare' to all P. T. A.'s and a committee of four is studying appropriate topics for schools. By request, a member has been designated to speak to high school girls on personal and social hygiene. For the fifth year, it has awarded a silver loving cup to the grammar school with the lowest percentage of remedial defects.

"The Chatham Auxiliary is answering requests to send Auxiliary members to speak to schools. It has over 26 members serving in organizations interested in health and public welfare.

"In 1930, when the Fulton County Medical Society was discussing the possibility of a new Academy of Medicine, the Auxiliary decided on an Investment Fund of not less than five years, to be used in furnishing a room for the Auxiliary. Now, the doctors have paid for the grounds and the Auxiliary has $853.00 in a separate account from regular Auxiliary funds, and will add to it in May."

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Baby's Proper Feeding The Doctor's Problem. One of the most frequent inquiries received by the State Department of Health is that concerning an infant's diet. It is, of course, impossible for the Department to advise or give suggestions regarding a suitable diet for any infant. It apparently is not generally realized by the laity, that food requirements vary for every infant. One infant may thrive on a given food while the next will not tolerate it. Consideration must be given to the fundamental requirements of each infant such as the protein, fat, carbohydrate, water, mineral and vitamin requirements. So far as is known, breast milk is the only universally suitable food for infants. If a baby is deprived of this he should be taken to the family physician and placed on a proper feeding. It is only after a thorough history has been taken and a thorough physical examination has been made that the proper food can be advised for any infant. It is quite obvious that such service is out of the realm of the State Department of Health.

The Department, however, has literature on infant care that is available on request. The Children's Bureau at Washington also publishes some excellent pamphlets on infant and child care which should be read by every mother who wishes to give her child the best of care and training.—*From Ohio Health News, Nov., 1934.*

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Borden Abstracts

A new book on food and health by an eminent authority, which is of especial value to physicians and their patients, is the subject of a review in Abstract No. 2089; and an article by the same distinguished author on our present knowledge of the vitamins is the basis of Abstract No. 2090.

Endorsement of Vitamin D milks, and the reasons therefor, as published in a report of a committee of the New York Academy of Medicine, are outlined in Abstract No. 2091; while an article on Vitamin D milks generally is reviewed in Abstract No. 2092.

Pasteurization of milk is stated in the article summarized in Abstract No. 2093, to be the only effective and reliable method of prevention of undulant fever.

Hookworm infestation in children can be reduced and the sequelae combatted by means of a diet of protective foods, according to the paper mentioned in Abstract No. 2095.

Proteins and carbohydrates are not incompatible in the human diet, as shown by the investigation reported in Abstract No. 2096, which effectively disposes of one of the current food fads.

In the dietary treatment of septicemia, milk and other soft foods are important, according to Abstract No. 2094.

The new edition of a standard book on condensed milk and milk powder, and a new book on biochemistry are reviewed in Abstracts Nos. 2097 and 2098, respectively.



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COUNTY SOCIETY	SECRETARY	MEETINGS				Dues Paid.
		Date	Time	Place	Luncheon?	
Alachua	Harry M. Merchant, M.D., Gainesville.	2nd Tuesday	12:00 Noon	White House Gainesville	Yes.	
Bay	Allen H. Miller, M.D., Millville.					64%
Brevard	Bob Schlernitzauer, M.D., Rockledge.	2nd Tuesday		Varies	Yes.	17%
Broward	Robert E. Blount, M.D., Ft. Lauderdale.	Last Wednesday.	8:00 P.M.	Elks' Hall Ft. Lauderdale	No.	
Columbia	T. H. Bates, M.D., Lake City.	1st Monday	7:30 P.M.	Blanche Hotel Lake City		100%
Dade	Robert T. Spicer, M.D., Miami.	1st Friday	8:30 P.M.	Club Room Huntington Bldg. Miami	Occasionally.	40%
DeSoto-Hardee-Highlands	L. W. Martin, M.D., Sebring.	2nd Tuesday	8:00 P.M.	Varies	Yes.	
Duval	Charles B. Mabry, M.D., Jacksonville.	1st Tuesday	8:15 P.M.	Mayflower Hotel Jacksonville	No.	43%
Escambia	J. M. Hoffman, M.D., Pensacola.	2nd Tuesday	8:00 P.M.	Board of Health Building Pensacola	No.	
Hillsboro	John S. Helms, Jr., M.D., Tampa.	1st Tuesday	8:00 P.M.	Tampa Municipal Hospital Tampa	No.	
Jackson	Lewis Pierce, M.D., Marianna.	2nd Tuesday	7:30 P.M.	Hotel Chipola, Marianna	Yes.	77%
Lake	W. L. Ashton, M.D., Umatilla.	1st Thursday	12:30 P.M.	Eustis	Yes.	68%
Lee	H. Quillian Jones, M.D., Ft. Myers.	3rd Friday	7:30 P.M.	Lee Memorial Hospital Ft. Myers	No.	80%
Leon-Gadsden-Liberty-Wakulla-Jefferson	O. G. Kendrick, M.D., Tallahassee.	Quarterly	3:00 P.M.	Varies	Yes.	71%
Madison	Geo. O. Davis, M.D., Madison.					
Manatee	W. D. Sugg, M.D., Bradenton.	3rd Tuesday	7:00 P.M.	Whitfield Country Club Bradenton	Yes.	
Marion	Richard C. Cumming, M.D., Ocala.	3rd Thursday	12:30 P.M.	Marion Hotel Ocala	Yes.	100%
Monroe	W. R. Warren, M.D., Key West.	1st Sunday	9:00 P.M.	Varies	Yes.	
Orange	John A. Pines, M.D., Orlando.	3rd Wednesday	8:30 P.M.	Varies	No.	
Palm Beach	Lloyd J. Netto, M.D., W. Palm Beach.	4th Monday	8:00 P.M.	Good Samaritan Hospital W. Palm Beach	No.	40%
Pasco-Hernando-Citrus	John J. Bourke, M.D., Dade City.	2nd Thursday	7:00 P.M.	Varies	Yes.	77%
Pinellas	O. O. Feaster, M.D., St. Petersburg	1st Friday	8:00 P.M.	Assembly Room, 5th floor, P. & L. Bldg. St. Petersburg	No.	79%
Polk	J. R. Boulware, Jr., M.D., Lakeland.	2nd Wednesday in Feb., Apr., June, Aug., Oct., Dec.	1:00 P.M.	Lakeland	Yes.	
Putnam	E. W. Warren, M.D., Palatka.	2nd Thursday	7:00 P.M.	James Hotel, Palatka	Yes.	57%
St. Johns	John L. Bennett, M.D., St. Augustine.	3rd Tuesday	8:30 P.M.	Varies	Yes.	7%
St. Lucie-Okeechobee-Indian River-Martin	J. D. Parker, M.D., Stuart.	3rd Thursday	8:00 P.M.	Varies	Yes.	
Sarasota	J. E. Harris, M.D., Sarasota.	2nd Tuesday	8:30 P.M.	Varies	Occasionally.	93%
Seminole	J. T. Denton, M.D., Sanford.	2nd Monday	7:00 P.M.	City Hospital Sanford	Yes.	100%
Sumter	W. E. Mitchell, M.D., Coleman.	2nd Tuesday		Varies	No.	
Taylor	C. A. O'Quinn, M.D., Perry.	Last Friday	8:00 P.M.	Dixie-Taylor Hotel Perry	Yes.	
Volusia	Hugh West, M. D., DeLand	2nd Tuesday	7:30 P.M.	Varies	Yes.	49%
Walton-Okaloosa	A. G. Williams, M.D., Lakewood.	3rd Thursday	8:00 P.M.	Varies	Occasionally.	100%

NOTE—Secretaries: Please submit information to complete the above schedule.



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THE JOURNAL

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VOLUME XXI
NO. 10

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NEXT SESSIONS

Florida Medical Association, Ocala, May 13, 14, 15, 1935.
American Medical Association, Atlantic City, June 10-14, 1935.
Southern Medical Association, St. Louis, November 19-22, 1935

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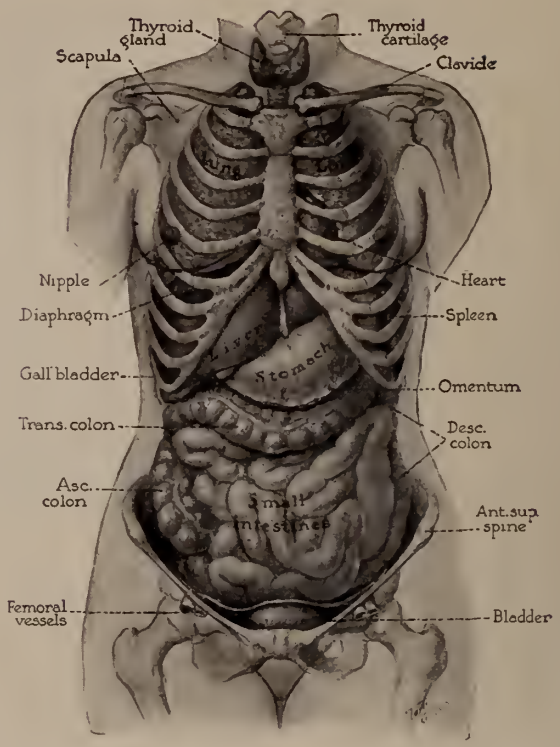
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TUBERCULIN IN THE TREATMENT OF ARTERIOSCLEROSIS*

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Orlando.

Arteriosclerosis is a hyperplasia of the connective tissue of the walls of the arteries. It does not exist alone but is accompanied by a general hyperplasia of all the connective tissue of the body, the cause of this hyperplasia being repair following cell destruction by some irritant, increased or modified in degree and selective location by various conditions.

Inflammation, the expression of the effort of a given organism to rid itself of or render inert noxious irritants arising from within or introduced from without, whether bacterial, chemic, or traumatic, is only a part of repair. The forms that these factors may assume are too many to attempt to enumerate the various etiologic elements leading to the various manifestations. This phenomena repair affects only connective tissue. Endothelium and epithelium merely lie on the surface as a protective, being affected only when the connective tissue below is irritated. So, injury to the connective tissue, whether mechanical, chemic, or thermal is followed by repair; the extent and severity of the inflammatory process depends upon a number of associated factors. Infection truly represents a chemic injury, the noxious irritant being the specific product of the infecting organism. Inflammation may be produced by the injection of bacterial products without the presence of bacteria. The whole list of inflammatory causes embraces the destruction of cells at every turn. The greater the injury or the more virulent the infection, the greater the cell destruction.

The inflammatory process induced by bacteria depends upon two factors. First, the pathogenic power of the germ in question: the infection may have a direct local effect, causing repair and hyperplasia of connective tissue only at the sight of the focus of infection. Its products, being absorbed and distributed throughout the body, may not have a destructive effect upon connective tissue cells and may even ameliorate or neutralize the irritating properties of other noxious agents. On the other hand, bacterial products may be decidedly irritating and assist or augment other irritating influences. Second, the degree of susceptibility of the tissues; this would include constitutionally inferior tissues or inherited tendencies to various conditions. All come in to alter the cause, resulting in different effects. The idea that there are exceptions to all rules is wrong. Each phenomena has its basic law, but like atoms, they do not exist alone and are accompanied by other phenomena. Any two or more in operation at the same time may inhibit or aid each other, resulting in modified or accelerated results. To illustrate: typhoid, tuberculosis, or any other malady would be identical in every case, but no two individuals are constructed the same, just as no two finger prints are the same, and then, other disorders may be present to alter the picture. So, forever and anon, things that are equal to each other are equal to the same thing.

We know that it takes a certain amount of blood circulating through the various organs to keep them properly functioning and nourished. In order that this amount of blood be constant, the blood pressure must rise or fall to compensate for the irregular capacity of the arteries and arterioles due to alterations in the lumen of the vessels, or degree of elasticity. This is automatically regulated through the sympathetic nerve system, the vasoconstrictors and dilators. When there is hyperplasia of the connective tissue wall of the blood vessel, its lumen is likely narrowed and elasticity diminished, resulting in a rise in blood pressure. With increased blood pressure, there is a greater strain on the heart, causing hypertrophy, this depending upon the pressure and length of time it has existed. In all cases of arteriosclerosis there should be high blood pressure and usually this is true. However, occasionally there is a normal pressure or only moderately high. This is due to the condition of the arterioles or unusually large blood vessel lumen.

Now this hyperplasia of connective tissue is

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abnormal and consequently this excessive tissue has not the vitality of the regular connective tissue, even having the tendency to become calcified or become embryonic or malignant in certain areas, and has always been considered permanent and progressive. So, is there an agent which will break down and absorb this excessive devitalized connective tissue? Scar tissue formation or hyperplasia of connective tissue is the great barrier to any hope in the treatment of such neurological conditions as paresis, locomotor ataxia, multiple sclerosis, and several others. This encouraged me to give the subject quite a bit of thought.

Changes in blood pressure are due to the strength of the heart, peripheral resistance in the vessels, elasticity of the vessel walls, the lack of which is most often the result of sclerosis. Viscosity of the blood has little to do with the blood pressure. In seventy-five per cent or more of cases of hypertension of any duration, there are definite signs of chronic interstitial nephritis with arteriosclerosis of varying degree. Arteriosclerosis may be more pronounced in different areas, but sclerosis of the sphanchnic vessels is a greater cause of hypertension. Sclerosis of the cerebral vessels may exist without noticeable sclerosis of the other vessels. In chronic interstitial nephritis, there is a sclerosis of the renal vessels. Wherever this sclerosis may be, general or localized, there is hyperplasia of connective tissue. This paper deals only with arteriosclerosis, the most common cause of hypertension, and not with some of the so-called essential hypertensions, or perhaps compensatory hypertension.

My personal observation throughout my entire medical career and information collected from others who had observed more cases of tuberculosis than I, brought to my attention that:

Practically all patients suffering with tuberculosis have a low blood pressure and tuberculosis is the most common cause of hypotension.

Arteriosclerosis in these cases is rare.

X-rays of chest always show very small hearts while in arteriosclerosis, the heart is practically always large.

I have noticed, personally, that tubercular patients retain their youthful appearance, as far as their skin or complexion is concerned, much longer than those with a tendency to arteriosclerosis.

I know of several people who came to Florida fifty or more years ago, because of tuberculosis, who are living now and in a fair state of preservation. I have one patient, 96 years old, who has prospects of living a few more years, at least to the 100 mark, barring some intercurrent affection, who undoubtedly had tuberculosis in his early life.

I had a patient who died two years ago at the age of 84, who went west at the age of 30 because of tuberculosis, and as late as 25 years ago, tubercular bacilli were found in his sputum. He died of cancer of the parotid gland, supposedly tubercular in the beginning because of the history of tuberculosis. Prior to the development of the cancer, he did not appear to be over fifty years of age.

It is true we find a few patients suffering with tuberculosis who have a high blood pressure, but in these cases it is my belief that there is some other condition accompanying it that neutralizes and overwhelms the hypotensive action of tuberculin, such as some foci of infection or abnormal internal secretion. However, they are comparatively few.

Sclerosis, in general, being one of the great problems confronting medical science, we are naturally always seeking some better method of treatment or something that will hold it in abeyance.

After analyzing and comparing conditions that existed with tuberculosis and arteriosclerosis, I decided to try tuberculin in the treatment of arteriosclerosis and observe its effect. Up to the present time, the most important treatment has been regulation of diet and elimination of work and worry.

About seventeen years ago, Dr. Wagner von Jauregg, of Vienna, observed beneficial effects in paretics subsequent to the occurrence of intercurrent infections and the idea occurred to him that an induced attack of malaria might be a very satisfactory means of artificially producing these benefits. So, he started this method of treatment, by inoculating the patient with malaria, with satisfactory results. It has also opened an avenue for investigation of the diathermic effect of fever in many conditions.

Space will not permit a report of all the cases treated; consequently, I will give you briefly an idea of results so far obtained.

Case No. 1.—Entered Orange General Hospital, July 16, 1933, at 4 p. m. Walked from ambulance to elevator and from elevator to room in ward. Had a definite motor aphasia which at

first was thought to be hysterical from history obtained from neighbors. They knew very little of her and she was unable to give any information concerning herself. She was apparently 65 years of age. She was referred to me as a psychopathic patient. Examination shortly after revealed no physical or neurological symptoms. This was on Sunday afternoon. Monday morning, she had a definite hemiplegia of the right side, reflexes exaggerated on same side, a perfect picture of cerebral apoplexy. Blood pressure was 200 over 100. I never do anything for these patients except keep them as motionless as possible for forty-eight hours. However, I had ordered a purgative in the beginning after ruling out any acute abdominal condition. July 26th, her blood pressure was 168 over 90 at 10 p. m. I gave her 1 minim old tuberculin diluted in about 1 cc. sterile water. July 27th, 8 a. m., her blood pressure was 124 over 70. At 10:30 a. m., her blood pressure had gone back to 152 over 72. July 28th, 9 a. m., blood pressure was 154 over 70; 9 p. m. blood pressure was 150 over 70. July 29th, 9 a. m., blood pressure 150 over 70; 8 p. m., blood pressure was 160 over 70, 1 minim old tuberculin given as before. July 30th, 10 a. m., blood pressure was 138 over 60; 9 p. m., 140 over 70. July 31st, blood pressure was 140 over 60. August 1st, blood pressure 140 over 70. August 2nd, blood pressure 130 over 60, 2 minims old tuberculin given. August 3rd, blood pressure 126 over 60. August 10th, blood pressure 150 over 70, 10 minims of a 1 to 50 dilution old tuberculin given. August 11th, blood pressure 134 over 70. This patient's pressure is still around 130 to 136 over 70 to 80, and she has not had any tuberculin since August 10th, 1933. This patient, of course, has been bedridden. That must be considered.

Case No. 2.—White, male, 66 years of age. Some time during May, 1933, he had an attack of angina pectoris. I started treatment September 1st. Blood pressure 200 over 126. He complained of insomnia, could not lie on his left side at all because the heart beat was so intense, he would have to turn over. Administered 10 minims of a 1 to 20 dilution old tuberculin. Had a rather severe reaction. Blood pressure dropped to 140 over 70 the following day. After the reaction had subsided, his blood pressure went back up to 160 over 100. September 7th, another injection of 10 minims of 1 to 50 dilution. Another reaction. Blood pressure dropped to 148 over 80. Four days later, I gave him 10 minims of a 1 to 100 tuberculin. His blood pressure was 150 over 90. Since that injection, lying on his left side does not disturb him and his insomnia has practically disappeared. He has been receiving tuberculin once or twice a week since. His blood pressure varies from 148 to 170 over 86 to 100. This patient still runs a blood pressure of 140 over 86 and sometimes jumps up to 180 over 100, but his general condition is very much improved. He eats and does anything he wants to, which he could not do before.

Case No. 3.—White, male, 48 years of age. February 16th, blood pressure was 216 over 138. Ten minims of a 1 to 100 dilution old tuberculin given. February 20th, blood pressure was 198 over 120. Twenty minims of 1 to 100 dilution given. February 23rd, blood pressure 180 over 108. February 27th, blood pressure 168 over 112. One cc. of 1 to 50 dilution given. March 2nd, blood pressure 158 over 102, 10 minims of 1 to 10 dilution given. March 6th, blood pressure 156 over 98, 1 cc. 1 to 10 tuberculin given. March 9th, blood pressure 152 over 96, 1 cc. of 1 to 10 dilution given. March 13th, blood pressure 150 over 92; 1 cc. 1 to 10. March 16th, 148 over 90; 1 cc. of 1 to 10 tuberculin given. March 20th, 146 over 88; 1 cc. of 1 to 10 given. March 22nd, 184 over 100. March 23rd, 200 over 110; 1 cc. of 1 to 10 given. March 28th, blood pressure was 170 over 100. March 30th, 160 over 96; 1 cc. of 1 to 10 given. April 3rd, 150 over 96, dosage remained the same after this, 1 cc. of a 1 to 10 dilution old tuberculin. April 10th, blood pressure 146 over 98. April 14th, blood pressure 148 over 90.

Case No. 4.—Female, 63 years of age. March 5th, blood pressure was 190 over 100; 5 minims of a 1 to 200 dilution given. Had some reaction. March 10th, 170 over 88; 5 minims of 1 to 200 old tuberculin given. March 14th, 150 over 80; 10 minims 1 to 200 given. March 19th, 140 over 80; 10 minims of 1 to 200 given. March 22nd, 142 over 76; 10 minims of a 1 to 100 dilution given. March 26th, 136 over 80; 10 minims of 1 to 50 old tuberculin given. April 2nd, 132 over 96; 10 minims of 1 to 50 given; April 6th, 130 over 82; 10 minims of 1 to 50 dilution old tuberculin given. April 11th, 124 over 78. April 19th, 130 over 80.

It is impossible to give a complete case history of these patients—merely the blood pressure and treatment with results. You can also appreciate

the disadvantage in securing clinical material from a private practice. However, I visited the Florida State Hospital at Chattahoochee the latter part of September and in October, 1933, and with the cooperation of the medical staff there, selected sixty-two cases as they came, of hypertension. This treatment was carried on in my absence by Doctors Pound, Beggs and Daves. But, due to the crowded conditions there, with insufficient number of doctors to care for the patients, it was impossible for them to continue this very long. However, I wish to thank the Medical Staff at Chattahoochee for their co-operation.

With these patients, and some I have found in the free clinics in Orlando, and some private cases, I have used tuberculin in over 100 cases. Whatever they have been doing, they have been allowed to continue; allowed to eat anything they desired, and the results have been approximately as follows:

60% marked improvement; 20% moderate improvement;

15% no change; 5% blood pressure increased, and treatment was stopped after one or two injections.

In this limited time and because of lack of clinical material, it is impossible to give an accurate estimate of the value of this treatment. The first thing you have to do is create a tolerance in the patient for the tuberculin, then give the maximum dose. Some respond readily, with others you have to continue its administration over an indefinite period.

I have had to change the dosage and frequency of administration from time to time as experience taught me better. At present, my method is as follows: I start with 5 minims of a 1 to 200 dilution old tuberculin given hypodermically every two to four days, gradually increasing dosage, depending upon the patient's tolerance for it. Eventually I give as much as 1 cc. of a 1 to 5 dilution old tuberculin every two days.

It is perfectly safe to give tuberculin in the doses prescribed above. The only contraindication is active tuberculosis, and even then the danger isn't as great as we have believed. There have been no untoward effects from its use in these cases.

From the very nature of arteriosclerosis, it is quite obvious that it will take at least two or three years' observation to determine the efficacy of any treatment.

In conclusion, I will say that there is nothing in literature that even approaches the subject. I am in hopes that some of you will join me in carrying on the investigation. If it is right, it is invaluable; if of no value, we will know it within the next year or so. I believe everything was created for good when properly controlled. Tuberculosis probably is not as great an evil as thought to be, and may even make adequate restitution for its past delinquencies. I am not sure of this. Complacency is the unpardonable sin. I will be glad to furnish you with any information that I have concerning this at any time.

LARYNGOFISSURE FOR CANCER OF THE LARYNX*

Report of Two Cases

William Patterson, M.D.,
Tampa.

Carcinoma of the larynx has been classified by St. Clair Thomson into intrinsic and extrinsic varieties. He says: "Intrinsic cancer might just as well be called cancer of the vocal cord, for it is rare for the disease to attack any other part of the interior of the larynx." The favorite site is the middle third or the anterior half of the cord.

Extrinsic cancer of the larynx does not form as well-defined a group as intrinsic cancer does. It starts in the epiglottis, arytenoids or outside of the larynx and has a tendency to early metastasis, whereas, intrinsic cancer of the cord is slow to metastasize because the lymphatic drainage of the interior of the larynx is poor and its cartilaginous walls resist direct invasion. For these reasons, Thomson says: "Treatment of intrinsic cancer of the larynx yields results in the way of lasting cure, which is not surpassed in any other internal organ of the body."

Laryngofissure for cancer of the larynx, which is our subject, is most suited and some authorities say, only suited, for cancer of the larynx when limited to the cord. On the other hand, laryngectomy presents the most favorable outcome for cancer of the larynx not located on the cord.

Jackson says: "Early removal of malignant disease of the larynx offers an 80% chance of cure, but if untreated, all these cases end in death."

Cancer of the larynx occurs in men eight times more often than in women. It is more common

*Read before the Florida Midland Medical Society, Bartow, October 25, 1934.

in men who have reached the age of forty and it increases with each subsequent decade to the age of seventy. After this age it is again less frequent.

Symptoms are primarily vocal and respiratory. Hoarseness, the early star symptom, is almost invariably present, being slight at first but persistent and progressive.

Tucker says: "Hoarseness is nearly always the first symptom and in order to make the required early diagnosis, the profession as a whole, not alone the laryngologist, must realize the frequently malign nature of chronic hoarseness in the adult." Hoarseness may remain more or less stationary for months and be very misleading to both the doctor and patient. The beginning of the trouble is often noticed following an attack of influenza or cold accompanied by an acute laryngitis. Chronic laryngitis is rare except in public speakers, singers, and others who tax their voices. Therefore, in every case of chronic hoarseness, an examination should be made of the larynx and if a growth is found on one cord, a malignancy may be present.

The principal causes of chronic hoarseness are tuberculosis, syphilis and tumors of the larynx. Tuberculosis that affects the cords is probably invariably secondary to pulmonary tuberculosis. Syphilis may cause hoarseness by direct involvement of the cord or through pressure of an aneurysm on the left laryngeal nerve. To help clear up these points, a Wassermann test, an x-ray examination of the chest, and of course medical consultation are necessary. But sometimes after a thorough examination, a differential diagnosis is not made. Dr. Mac Kenty reported a case in which syphilis, tuberculosis and cancer were all present.

Examination of the larynx by the indirect and direct methods is very helpful in a diagnosis. But Tucker says: "Prior to any major procedure laryngofissure, laryngectomy or extensive radiation, the diagnosis of cancer of the larynx should be confirmed by biopsy." St. Clair Thomson says: "There is not nearly the danger of immediate metastasis after the removal of tissue from the larynx for biopsy as was formerly presumed," and recommends it in all doubtful cases.

With the Lynch suspension apparatus and with the aid and advice of Dr. J. C. Chandler of Tampa, we removed a specimen for biopsy in one of our cases. The other case required no biopsy since it was so far progressed that there was no question in our minds but that it was malignant, which was verified after removal.

The technique we followed in doing the operation was that developed by Chevalier Jackson.

We used a general anesthetic in one of our cases and a local in the other. I prefer the general anesthetic. We did a preliminary tracheotomy a few days before in one case and the combined operation in the other.

The patient, before the operation, is placed on his back with shoulders raised and the head and neck extended, which renders handy the parts to be operated and prevents the aspiration of blood and mucus into the lungs. A midline incision is made through the skin and superficial fascia from the hyoid bone down to the suprasternal notch. The deeper tissues are severed in the midline, exposing the thyroid cartilage and the cricothyroid membrane. Then one blade of strong scissors is inserted through this opening to the thyroid notch of the larynx and the cartilage is divided in the midline. The wings of the cartilage are retracted and the growth is now plainly seen. The larynx is packed below above the tracheotomy tube, with gauze. The internal perichondrium is dissected backward one centimeter beyond the margin of the growth. The perichondrium, including the growth well into the healthy tissue, is removed. The external perichondrium over the cartilage which has been denuded is dissected forward and the wing of the thyroid cartilage beneath, removed.

The cartilage and perichondrium and then the skin are brought together. The patient is returned to bed with the head and shoulders elevated. The packing is kept clean with gauze dressings saturated with 1-10000 bichloride solution. He is given nourishment and plenty of fluids through a tube in the nose for a few days. No opiates are used for they prevent the lung expelling the secretions that accumulated.

The recovery after this operation is very rapid. The tracheotomy tube is removed in twenty-four to forty-eight hours. In a few days the opening in the trachea closes and the patient makes a rapid recovery. These patients develop a usable

voice and are not nearly so much handicapped as might be expected.

Case 1.—A man, age sixty-four, resident of Tampa, no occupation, was seen by me in the clinic of the Tampa Municipal Hospital, August 17, 1931.

He first consulted a physician eighteen months before for hoarseness. He was told, at that time, that he had a growth in the larynx and was advised to go to a doctor in a distant city for treatment. He had no money, so continued to get worse until we saw him in the clinic in a very bad condition. He was aphonic and unable to breathe while lying down.

This was not a suitable case for the laryngofissure operation for the growth had extended beyond the right cord into the aryepiglottic fold. But the patient would not consent to a laryngectomy.

We used the Jackson technique in doing the operation a description of which has been given. The combined operation, tracheotomy and laryngofissure, was done at the same time. The growth including the internal perichondrium and right thyroid ala was removed, going as far beyond the growth as we thought it extended. The wound was closed. The dressings were kept saturated with 1-10000 bichloride. The patient for a few days was fed through a tube in the nose. He made a quick recovery, leaving the hospital in ten days. For four months he was well and happy, but there was a recurrence and he died about a year later. He refused post-operative x-ray treatment which should always be given.

Case. 2.—A man, age forty-five, resident of Tampa, cigar maker, was seen in my office February 9, 1933, because of hoarseness of six weeks' duration following influenza. Jackson says these patients often date their trouble from an attack of acute laryngitis, cold or influenza which is misleading at first, in making a diagnosis. He had no other complaint. X-ray of the chest was essentially negative. Wassermann was negative.

On mirror examination, the whole larynx was more or less congested, and it was hard to get a good view of the parts because the patient was nervous and the reflexes active, which is often the case on first examination of the larynx. I did not see the growth at this examination and treated the case as a subacute laryngitis.

When he returned a few days later, the congestion had somewhat subsided and I could see a very small greyish mass on the anterior third of the right vocal cord, not extending to the commissure. After the laryngitis cleared up, the small growth remained and the patient continued with the same hoarseness.

On March 18, 1933, which was five weeks from the time I first saw the patient, by the Lynch suspension method, we removed a piece of the growth for biopsy.

On examination of the specimen, Dr. H. R. Mills made the following report:

"The tissue from Mr. C. G. is a small solid mass measuring 4 by 2 mm. Microscopical sections are covered on one side with squamous epithelium. In the underlying tissue are a few small groups of dark-stained undifferentiated epithelial cells, which I am obliged to interpret as carcinoma.

"Laboratory opinion: Carcinoma of the vocal cord."

On the strength of this report, on March 24, 1933, we did a preliminary tracheotomy and six days later did a laryngofissure by the Jackson technique. The growth extending well into the healthy tissue was removed, together with the underlying internal perichondrium and thyroid cartilage, but not including the external perichondrium.

The wound was closed and this man got along well until the third week, when a considerable amount of granulation tissue had accumulated over the denuded area. He was given x-ray treatments and the granulations disappeared in a short time, but he had a perichonditis following the x-ray treatments that gave him trouble for some weeks.

At this time, over eighteen months since the operation, there has been no return of the growth and the man has a usable voice which does not handicap him in making a livelihood.

CONCLUSION

I wish to say that my reason for reporting these cases is to bring out that laryngofissure for early cancer of the cord is not a difficult operation. The poor patient, who is not able to bear the expense of going to a distant medical center, can and should be taken care of by his local physician as soon as the diagnosis is made and not allowed to pass into an incurable condition, which most of them will do if not taken care of at home.

TORSION OF THE MESENTERY*

DUNCAN McEWAN, M.D.,
Orlando.

Torsion of the mesentery consists of a twisting of the mesentery at its comparatively narrow pedicle which results in a cutting off of the blood and nerve supply of the small intestine, resulting in thrombosis of the mesenteric vessels and eventual gangrene of the gut.

There may be a complete torsion or a partial torsion of the mesentery or there may be a temporary torsion which may relieve itself after giving vague gastro-intestinal symptoms.

The pathology of the condition consists of the twisting of the mesentery, usually in a clockwise direction, varying from 180 to 720 degrees. Less twisting may not cause any interference with the nerve or blood supply, but more severe torsion results in the formation usually of two firm bands, one near the ileum and the other further up toward the duodenum. The circulation of the mesenteric vessels is cut off, as well as the nerve supply, stasis of the gut takes place with congestion of the vascular system, the vessels then become thrombosed and then the gut becomes gangrenous. Peritonitis of the visceral and the parietal peritoneum usually sets in and the gut of the mid-portion of the ileum usually is the first to become gangrenous.

What is the etiology of this condition; why do some people have it and others not? First, there are certain developmental defects which lead to this condition. The intestinal tract may be retarded in its development resulting in an extremely long mesenteric attachment which, because of its length, is very prone to twisting. This is usually the case, especially in infants where torsion of the mesentery develops and is perhaps the most easily explainable cause and one of the most frequent. Another cause is adhesions of the gut to the parietal peritoneum which gives the intestine an axis on which to twist itself. Other predisposing causes are former operations, hernia, fibrous bands, cysts of the mesentery, chronic mesenteritis and chronic intestinal stasis.

Exciting causes which may bring this condition on are heavy lifting or straining, trauma to the abdomen and violent peristalsis of the gut, as brought on by catharsis and fermentative distension.

The symptoms vary with the partial torsion and the complete torsion. The partial torsion may result only in vague abdominal complaints with intermittent attacks of obstipation. In the complete torsion there are usually symptoms of excruciating pain, not definitely localized but usually in the umbilical region. This may be followed by vomiting, but never of a fecal nature for the small bowel cannot empty itself in either direction. The abdomen is distended and may be tender over its entirety, but there is no localized tenderness. The temperature is normal and the pulse is only slightly raised until collapse, when the pulse rises quickly. Results may be obtained at first from colonic irrigations and there may be blood, as in ordinary mesenteric thrombosis, but after the large bowel is cleaned out, the returns are clear.

The prognosis is always very serious, becoming more grave as operation is delayed. T. C. Lawton, in 1927, reported a case with recovery following operation and reviewed the literature until that time. Since then A. N. Polit has reported a fatality after late operation and J. E. Canessa has reported two cases, in one of which the patient recovered. C. Oberling has reported three cases in children. This case makes the 84th to be presented in which 26 patients have lived following operation or a mortality of 69%. No recoveries have been reported where operation has been delayed 48 hours after onset.

In operating, a diagnosis of axial torsion is made when no other cause of obstruction can be found and when further search reveals the constricting bands of the mesentery. The small intestine is uniformly dilated, distended and often hinders in palpation of the root of the mesentery. The operation consists of evisceration and restoring of the viscera to their normal position. General anesthesia is contraindicated; local and spinal anesthesia should be used.

CASE REPORT

J. S.—a male, age 49, was admitted to the hospital with the history of an illness of a fifty-two hour duration. While sitting quietly at home, he suddenly broke out in a cold sweat and felt very weak. He had no pain or other complaint at this time. Within the next twelve hours he vomited once and had one bowel movement of a well-formed stool mixed with bright red blood. Following this enemata given returned clear. During the second twelve hours he vomited twice, the vomitus consisting of food just eaten. Then

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thirty-six hours after onset he noticed that the abdomen was beginning to enlarge and that he had a steady dull pain throughout the abdomen which was more acute in epigastrium. He began to vomit dark brown sour-smelling vomitus which continued until admission.

No history of a predisposing cause was obtainable except that the patient had been doing hard lifting work on a moving van the day before the onset. He had had no previous operations and his past history was negative save for pneumonia twenty-five years previously and the indulgence in an occasional alcoholic spree. He gave no history of previous gastro-intestinal disturbance.

The patient was able to answer all questions, but he appeared acutely ill and presented a drawn and worried facies. Respirations were short and rapid, 40 to the minute; temperature was 98.4 and pulse 100.

Physical examination was negative save for evidence of dehydration and for abdominal signs. The abdomen was tense, tympanitic and markedly distended. There was moderate tenderness on palpation of entire abdomen, but no rebound tenderness. There were no masses palpable. The right inguinal ring was enlarged but there was no evidence of a strangulated mass. Rectal examination was negative.

A diagnosis of intestinal obstruction due to mesenteric thrombosis or intussusception was made and the patient was prepared for operation. The patient's condition had become much worse; the pulse was weak and thready and operation seemed almost hopeless.

A laparotomy was performed under spinal anesthesia and the entire small intestine was found to be gangrenous. Patient was moribund and abdominal cavity was closed without determining the cause of gangrene. The patient expired on the table, fifty-four hours after onset of the attack.

A necroscopy was performed and a general peritonitis was found. There was marked distension of the duodenum and jejunum and ten feet of the ileum were gangrenous. The mesentery was found to be longer than usual and twisted upon itself in a clock-wise direction about 360 degrees. As a result of this twisting, the root of the mesentery formed a hard band which compressed and partially obstructed the jejunum. Upon section of this band all the vessels were found to be thrombosed. A diagnosis of complete torsion of the mesentery with mesenteric thrombosis was made.









OCALA The Convention City



Less than half a century after the discovery of America by Christopher Columbus, the attractions of that section of central Florida of which Ocala is the present center, had become so favorably known as to stamp it a winter resort. The first tourist party, with eyes towards this area, was piloted by a Spanish conductor, who wanted his charges to enjoy a splendid cross-section of the peninsular state.

In July, 1539, Hernando de Soto, in a letter written at Espiritu (now Safety Harbor), made this statement: "We are now on our way to winter at the Ocali, (referring to the general area of which the present Ocala is the center) and if we find it as pictured, our hearts shall desire for nothing."

Stretching from the St. Johns River on the east to the Gulf of Mexico on the west; with Bushnell (Dade Memorial Park) as the southern boundary and Gainesville the northern limit, both the Spanish and Indians found a place delightful to the eye and where it was easy to obtain game and fish of almost every variety known to man.

Records of those early days shed much light on the meanderings and skirmishes; the accomplishments and defeats of those in whose bosoms was the urge to penetrate the fastnesses of the giant hardwood hammocks, ornamented with the Florida tropical palm.

In considering the history of that territory of which Ocala is the present capital, one cannot disassociate the daring exploits of the Seminole Indians, whose Chief was Osceola. It is quite enough to read the record associated with the Military Post, Fort King, in order to be convinced as to the leadership of the intrepid leader, Osceola.

With Fort King disbanded and the Indians driven out, the curtain rises and the Carolinians, aided by their Georgia brothers, pioneered into this area. Colonial plantations, typical of the deep south, sprang up. By the time of the early days of the Civil War, Ocala had gained considerable prominence and had already begun to point to the development of the surrounding countryside.

It was but natural that the leadership of the Confederacy was to be augmented by brave sons living in that territory hallowed by the early Timuquanan Indians, from whose customs and traditions "The Kingdom of the Sun" was coined. This is now the effective slogan of growing importance for Ocala and Marion County.

Following the Civil War period, cotton continued to be the principal industry for several years, to be joined by citrus, the advent of which was to assist in revolutionizing the habits, customs and financial standing of the state. Later, vegetables, general farming, livestock, dairying and poultry farming were to play an important part in the advancement of this section of the state.

With the cutting of the last appreciable timber stands, it remained for minerals to come into their own, thereby providing employment for hundreds of laborers and supplying tonnage for the railroads.

Before the last named industries had reached their peak, yet another attraction appeared on the horizon of Marion County and it is that, added to agriculture and a commercial distribut-









Convention Headquarters Hotel

ing center, to which the citizens are now addressing themselves with a more enlightened and enthusiastic interest . . . the tourist industry. Silver Springs, called by the Indians, *Chattawa Vianaugua Chattawa Vianaugua,* is drawing multiplied thousands of nature lovers to inspect the Infinite's handiwork underneath the water's surface. Scientists, geologists, artists, motion picture cameramen, college professors, students, globe-trotters and many others come to Silver Springs, Florida's international attraction, for that glass-bottom boat excursion that beggars description.

Within a twenty minutes' drive from the Springs is the Ocala National Forest, as unique as it is interesting. From lookout towers one may scan the landscape for miles and miles across "The Sea of Velvety Green," as the Ocala National Forest was recently called by a Florida editor who had motored through it. Recreation camps have been established by the Forest Service, so that visitors may refresh themselves . . . drink pure spring water, fish, swim and, in season, hunt.

Eighty mile loop drives are now possible in the Ocala National Forest—in this area of some 262,000 acres (gross)—which enables the motorist to observe a variety of plant life, elevations, land islands, clearwater lakes, spots of virgin timber, quiet retreats in Nature's parlor, and a general landscape as restful as it is interesting.

Tucked away in the heart of the Ocala National Forest is a Federal game preserve of 56,000 acres, in whose embrace is being preserved and protected a game supply that will increase and add to the pleasure of the hundreds of thousands coming to Florida. Present plans of the Federal Government point to the Ocala National Forest becoming one of the largest in the entire South.

A community, in order to be well balanced must take pride in its schools and churches, those institutions which help to extend the moral, cultural and intellectual horizon of its citizens.

"Marion County's school system is in good financial condition", State Auditor Willis said on March 8, 1935. In the thought expended on its schools, Ocala has wisely planned its general layout. Six solid city blocks compose Ocala's central school plant, bordered by palms which act as Nature's own curtain to somewhat shelter from view the school children at play.

With eight denominations having their own houses of worship, Ocala is served by the leading Protestant and Catholic bodies. Ocala citizens and the visitors who share the city's salubrious climate recognize the general elevating power of the churches and the needs to which they minister and give of themselves in helping to maintain these guide posts to the higher values of life.

The City of Ocala and the County of Marion planned more wisely than they knew in expanding hospital facilities. The city-county hospital, the Munroe Memorial Hospital, an institution of eighty-seven bed capacity has been erected and modernly equipped so that it may minister, effectively, to the needs of the community.



PROGRAM

of the

SIXTY-SECOND ANNUAL MEETING

of the

FLORIDA MEDICAL ASSOCIATION, Inc.

TO BE HELD AT OCALA, FLORIDA

MAY 13th, 14th, and 15th, 1935

INFORMATION

Information desk will be located in the lobby of the headquarters hotel, The Marion Hotel, with continuous service throughout the meeting. All members will be required to register and secure identification badges before attending any of the sessions. Guests and ladies are requested to register. Tickets for the dinner, Tuesday evening, May 14th, may be obtained at the registration desk.

HOTELS

Hotel Marion—Convention Headquarters.

RATES (European Plan)

	Single	*Double*
Ocala Highlands	$2.50 to $4.00	$4.00 to $6.00
Marion	2.00 to 3.50	3.00 to 6.00
Silver Springs Court	2.00	3.00
Harrington Hall	1.25 to 2.00	2.00 to 3.50
Hoffman	1.25 to 1.50	2.50 to 3.00
Florida House	1.00 to 2.00	2.00 to 3.00
Colonial	1.00 to 2.00	1.50 to 2.50
Ocala House	1.00 to 1.50	1.50 to 2.00

(Some hotels do not have private bath in every room)

TECHNICAL EXHIBITS

Technical exhibits will be located in booths in lobby of the Hotel Marion.

The technical exhibits have a real scientific value and physicians who wish to keep abreast of the times and know the latest in drugs and medical appliances should spend some time with these exhibits. It will be surprising the amount of useful information that can be procured at these exhibits. Many have nothng for sale, the representatives of the firms being there to give the latest information regarding their products. Those who have items for sale will gladly give information whether there is a purchase or not. Be sure to register your name with the various representatives who are exhibiting.

The following firms have arranged for exhibits at the Ocala meeting:

American Optical Co.
H. G. Fischer & Co., Inc.
C. B. Fleet Co.
General Electric X-ray Corp.
Gerber Products Co.
Mead Johnson & Co.
Keleket X-ray Co.
Philip Morris & Co, Ltd.
E. R. Squibb & Sons
Surgical Supply Co.
White Belt Dairies Laboratories

ENTERTAINMENT

GOLF

The golf tournament will be held Tuesday, May 14. All members participating in the tournament are asked to hring their handicaps, signed by their club secretary or club professional. No handicap of over 27 will be allowed. Please turn in your handicap promptly on arriving in Ocala to Dr. J. N. Moore, chairman of the Committee, or at the registration desk.

Prizes for the tournament will be presented as follows:

1st prize: Orlando Cup (low net score)

2nd prize: Runner-up (2nd low net score), physician's leather bag, donated by Mr. Henry Parramore, President of Surgical Supply Co.

3rd prize: (Low gross medal score), one dozen golf balls, donated by the Marion County Medical Society.

4th prize: Consolation.

A golf luncheon will be held at the Ocala Highlands Club at 12:30 p. m., May 14. All members playing in the tournament are urged to attend this luncheon.

Greens fees (for guests showing F. M. A. badges) 75c.

FISHING TRIPS

Fishing trips for individuals or groups will be arranged during the annual meeting. The Anglers' Committee suggests that Sunday morning, May 12, is a convenient time. During the convention, information concerning fishing trips may be secured through Dr. Ralph Russell, Chairman, Ocala. If you are unable to locate Doctor Russell, you are requested to leave a message at the registration desk. If you are planning a fishing trip, please communicate with Doctor Russell, Ocala.

SWIMMING

Swimming at Silver Springs. Bring your swimming suits.

Tuesday, May 14th

7:30 p.m. Association Dinner. Marion Hotel. Dr. H. C. Dozier, Ocala, toastmaster; Dr. Stewart R. Roberts, Atlanta, guest speaker. Tickets ($2.50) may be obtained at the registration desk. Following the dinner, there will be dancing at the War Memorial Home.

OFFICERS OF MARION COUNTY MEDICAL SOCIETY

James L. Chalker, *President*
J. N. Moore, *Vice-President*
R. C. Cumming, *Secretary-Treasurer*

LOCAL COMMITTEES

Cabinet Committee

E. G. Peek, Chairman
J. L. Chalker
R. C. Cumming
H. C. Dozier
R. D. Ferguson
A. H. Freeman
E. G. Lindner
J. N. Moore
R. E. Russell
T. H. Wallis
H. F. Watt

Committee on Registration

A. H. Freeman

Committee on Exhibits

J. L. Chalker, Chairman

Committee on Association Dinner

T. H. Wallis, Chairman
H. C. Dozier

Committee on Hotels

R. D. Ferguson, Chairman
Carl Lytle

Committee on Publicity

H. C. Dozier, Chairman
Henry Gatrell

Committee on Projecting Lantern

J. N. Moore, Chairman
E. G. Lindner

Anglers' Committee

R. E. Russell, Chairman
K. R. Cammack
T. K. Slaughter

Golf Committee

J. N. Moore, Chairman
R. C. Cumming

Ladies' Advisory Committee

E. G. Lindner, Chairman
I. E. Martin

Finance Committee

R. C. Cumming, Chairman
J. L. Chalker

Alumni and Fraternity Committee

H. F. Watt, Chairman
J. L. Strange
R. C. Cumming

FIRST GENERAL SESSION

Monday, May 13th, 4:00 p. m.

Dixie Theatre

Call to order, Eugene G. Peek, Chairman of Convention Committee.
Invocation, The Reverend John A. McMurray, pastor First Presbyterian Church, Ocala.
Address of Welcome, Honorable B. C. Webb, Mayor of Ocala.
Introduction of Georgia Delegates.
Announcements.
President Pearson in the Chair.
Report of officers and committees:
Secretary-Treasurer-Editor, Shaler Richardson, and Business Manager, Stewart Thompson.
Executive Committee, Leland F. Carlton.
Committee on Legislation and Public Policy, Julius C. Davis.
Hospital and Medical Education Committee, Harry F. Watt.
Council, F. Clifton Moor.
Committee on Necrology, Henry E. Palmer.
Public Relations Committee, J. Ralston Wells.
Committee on Post-Graduate Work, T. Z. Cason.
Committee on Cancer Control, Gerry R. Holden.
Committee on Medical Economics, Henry C. Dozier.
Advisory Committee to Woman's Auxiliary, Gordon H. Ira.
Committee on State Hospitals for Insane, Ralph Greene.
Inter-Relationship Committee, William M. Rowlett.
Tuberculosis and Public Health Committee, M. Jay Flipse.
Feeble-Minded and Venereal Disease Control Committee, Henry Hanson.
Committee to Study Contraception and Therapeutic and Eugenic Sterilization, Joseph S. Stewart, Jr.
Committee on A. M. A. Convention to Florida, Ralph Greene.
Delegates to A. M. A., Bundy Allen and Meredith Mallory.
Special Committee Reports.

FIRST MEETING OF HOUSE OF DELEGATES

Monday, May 13th, 8:00 P. M.

Dixie Theatre

President Pearson in the Chair.
Roll Call and Seating of Delegates.
Adoption of Minutes as published in May, 1934, Journal.
Election of one delegate and one alternate to A. M. A. meeting for two-year terms.
Selection of meeting place of Association for 1936.
Consideration of proposed amendments to Constitution.
Reading of Resolutions.
New Business.
Announcements.
Adjournment.

SCIENTIFIC ASSEMBLIES

Dixie Theatre

Committee on Scientific Work: Gilbert S. Osincup, Orlando; Louie M. Limbaugh, Jacksonville; Joseph S. Stewart, Miami.

Attention is called to the following By-Laws:

"All papers read before the Association shall be its property. Every paper shall be deposited with the Secretary when read."

"No address or paper before the Association, except those of the President and Orator, shall occupy more than fifteen minutes in its delivery, and no member shall speak longer than five minutes, or more than once on any one subject."

The Duval County Medical Society has offered its projecting lantern and daylight screen for use during the convention. Mr. Henry Parramore and his staff of the Surgical Supply Company will operate the projector and look after the showing of slides for essayists. Essayists wishing to illustrate their papers with lantern slides should communicate with J. N. Moore, Ocala, chairman of the committee in charge.

FIRST SCIENTIFIC ASSEMBLY

Tuesday, May 14th, 9:00 to 10:30 A. M.

Dixie Theatre

1. "Friedman Test for Pregnancy. Report of Two Hundred Cases," Herbert R. Mills, Tampa.

 The Friedman test, the most reliable test for pregnancy, at the present time. Review of principle. Report of two hundred cases, ninety-six and a half per cent of which prove to be correct. Analysis of all cases in which tests result falsely. Indications for improvement in technique.

2. "Obstetrical Liabilities," Samuel R. Norris, Jacksonville.

 Study of 2,500 consecutive cases in local hospital. Analysis of consultations; work of 75 different physicians. Attempt to determine the extent of physicians' share in the various liabilities; most of errors grouped under a few main headings.
 Discussion of these headings; treatment; suggestions for improvement. Plea for better obstetrics.

3. "Maternal Mortality," Henry Hanson, Jacksonville.

 Statement of maternal mortality covering last decade. The practice of obstetrics and midwifery and laws bearing on subjects. Program of the State Board of Health for lowering mortality. The practicing physician and his responsibility. The midwife, her qualifications record. Mortality trends during 1934. Duties of the state and county societies to determine causes of the high maternal mortality.

SECOND GENERAL SESSION

Tuesday, May 14th, 10:30 A. M.

Dixie Theatre

Call to order, Homer L. Pearson President.
Presidental Address: "The Physician and his Government", Homer L. Pearson, Miami.
Address (by invitation), "Arthritis", James E. Paullin, Atlanta, Ga.

SECOND SCIENTIFIC ASSEMBLY

Tuesday, May 14th, 2:00 to 5:00 P. M.

Dixie Theatre

4. "Florida Sores," Chadbourne A. Andrews, Tampa.
 A resume of the common skin diseases encountered in Florida, including impetigo, ring-worm, infections, larva migrains, scabies. Diagnosis and management of these conditions together with photographic illustrations.

5. "The Care of Cataract Patients," Shaler Richardson, Jacksonville.
 Discussion of management of the patient afflicted with cataract. The necessity of seeing patient early. The cooperation of general physician is most important and every cataract patient should have careful diagnostic study. Operative methods with analysis of the various procedures.

6. "The Tonsil Problem," L. C. Ingram, Orlando.
 The tonsil problem is of interest to everyone in the practice of medicine for at some time it will be necessary for each one to decide whether or not the disease under investigation can be the result of an infection in the tonsils. Billings' theory of focal infection was the most important contribution to introduce the tonsil problem. Improved tonsil instruments and the adoption of tonsillectomy about the same time contributed most to the solution of the problem.

7. "Observations on the Mechanism and Treatment of Circulatory Failure" (lantern slides), E. W. Bitzer, Tampa.
 A complete review of mechanical considerations including cardiac defects, obstruction in the vascular system, metabolic considerations, cardiac arhythmias, cardiac failure and treatment.

SECOND MEETING OF HOUSE OF DELEGATES

Tuesday, May 14th, 5:00 P. M.

Dixie Theatre

Unfinished business.

THIRD SCIENTIFIC ASSEMBLY

Wednesday, May 15th, 9:00 to 12:00 A. M.

Dixie Theatre

8. "Boils and Carbuncles," J. R. Chappell, Orlando.
 Short review of the history of boils and carbuncles. The pathology and underlying causes of boils and carbuncles, with especial emphasis on the so-called recurring crops as well as the seasonal crops. A discussion of the blood sugar determination and carbohydrate metabolism, as they affect boils. A brief analysis of the literature regarding the treatment of boils and carbuncles, discussing the incision versus the non-incision method of treatment, ending with the author's choice of treatment.

9. "Principles of Plastic Surgery of Benefit to the General Surgeon" (lantern slides), Thomas O. Otto, Miami.
 Plastic surgery is best defined as our attempt to restore normal function to a part congenitally lacking or lost by trauma or disease. The principles of plastic surgery which we, as general surgeons, can best employ are incision. Zeta incision, reverse Zeta incision, and grafting. These principles will be illustrated by means of lantern slides.

10. "Infections and Treatment of Cervix Uteri," W. C. Payne, Pensacola.
 The routes by which infections travel from cervix to uterine adnexa. Discussion of histopathology of cervical erosions urging more frequent use of electric cautery in treating lesions of cervix uteri.

11. "Immunization Against Contagious Diseases of Childhood" (lantern slides), Warren Quillian, Coral Gables.
 Summary of problems and methods in scarlet fever, diphtheria, pertussis and measles. Slides reviewing comparative value of various types of immunization in personal experience of author. Conclusions.

THIRD GENERAL SESSION

Wednesday, May 15th, 12:00 Noon

Dixie Theatre

President Pearson in the Chair.
Unfinished Business.
New Business.
Dr. Herbert L. Bryans escorted to the Chair as new President.
Presentation of Past-President's Button to Dr. Homer L. Pearson.
Election of President-elect.
Election of First Vice-President.
Election of Second Vice-President.
Election of Third Vice-President.
Election of Secretary-Treasurer.
Adjournment.

PROGRAM FOR WOMEN

Local Committees

General Chairman of Arrangements, Mrs. E. G. Lindner

Registration Committee

Mrs. E. G. Peek, Chairman — Mrs. William Cumming
Mrs. J. Walter Hood — Mrs. T. H. Wallis

Bridge Party Committee

Mrs. R. D. Ferguson, Chairman — Mrs. A. G. Brown
Mrs. H. C. Dozier — Mrs. J. L. Strange

Luncheon and Boat Trip Committee

Mrs. J. N. Moore, Chairman — Mrs. R. D. Ferguson
Mrs. J. H. Van Engelken — Mrs. W. V. Newsome
Mrs. I. E. Martin

Monday, May 13th

4:00 p.m. Executive Board Meeting at suburban home of Mrs. E. G. Peek, followed by Buffet Supper for Board Members.

8:00 p.m. Bridge Party or Picture Show (optional).

Tuesday, May 14th

9:30 a.m. Business Meeting in Hotel Marion to be followed immediately by Post Convention Board Meeting.

1:00 p.m. Luncheon for all visiting ladies at Silver Springs, followed by glass-bottom boat trip over Springs.

7:30 p.m. Association Dinner at Marion Hotel. Dance.

PROGRAM OF THE SIXTEENTH ANNUAL MEETING OF THE FLORIDA RAILWAY SURGEONS' ASSOCIATION

The Florida Railway Surgeons' meeting will be held Monday morning, May 13, 1935, at the Dixie Theatre Building, Ocala, Florida.

A preliminary announcement has been made that a symposium on "Injuries Particularly Interesting to Railway Surgeons" will be the main feature of the program. The following topics will be presented:

1. "The Handling of Acute Injuries as Pertaining to the Eye, Ear, and Nose."
2. "The Handling of Acute Injuries from an Executive Point of View."
3. "The Handling of Acute Injuries in Regards to the Head."
4. "The Handling of Acute Injuries from an Economic Point of View."
5. "The Handling of Acute Injuries as Regards Fractures."

A complete program will be available at the registration desk Monday morning when the members of the Railway Surgeons' Association arrive.

FOURTH ANNUAL SPRING MEETING OF THE FLORIDA RADIOLOGICAL SOCIETY

Monday, May 13th

Harrington Hall

10:00 a. m. Radiological Conference.

REGULAR QUARTERLY MEETING OF THE FLORIDA SOCIETY OF DERMATOLOGY AND SYPHILOLOGY

Monday, May 13th

Hotel Marion

12:30 p.m. Luncheon.
Election of Officers.
Clinical Session.

MEETING OF FELLOWS, SOUTHEASTERN SURGICAL CONGRESS

Monday, May 13th

Harrington Hall

6:00 p.m. Supper, followed by Business Meeting.

ALUMNI AND FRATERNITY LUNCHEONS

Tuesday, May 14th

12:30 p.m. Emory Medical Alumni Association.
12:30 p.m. Phi Beta Pi Fraternity.



PAST PRESIDENTS

1885—Dr. Joseph Y. Porter, Key West.*
1886—
1887—
1888—
1889—Dr. R. P. Gary, Ocala.*
1890—Dr. J. Harris Pierpont, Pensacola.
1891—Dr. Sheldon Stringer, Brooksville.*
1892—Dr. R. A. Lancaster, Gainesville.*
1893—Dr. J. D. Rush, Apalachicola.*
1894—Dr. R. P. Daniel, Jacksonville.*
1895—Dr. C. B. Sweeting, Key West.*
1896—Dr. H. K. DuBois, Port Orange.*
1897—Dr. R. B. Burroughs, Jacksonville.*
1898—Dr. R. P. Izlar, Ocala.*
1899—Dr. J. Harrison Hodges, Gainesville.
1900—Dr. W. H. Hughlett, Cocoa.*
1901—Dr. J. Harris Pierpont, Pensacola.
1902—Dr. J. Harris Pierpont, Pensacola.
1903—Dr. DeWitt Webb, St. Augustine.*
1904—Dr. E. N. Liell, Jacksonville.*
1905—Dr. J. M. Jackson, Miami.*
1906—Dr. John MacDiarmid, DeLand.*
1907—Dr. W. P. Lawrence, Tampa.*
1908—Dr. J. F. McKinistry, Gainesville.*
1909—Dr. Henry E. Palmer, Tallahassee.
1910—Dr. J. D. Love, Jacksonville.*
1911—Dr. A. H. Freeman, Ocala.
1912—Dr. John S. Helms, Tampa.*
1913—Dr. P. C. Perry, Jacksonville.
1914—Dr. F. C. Moor, Tallahassee.
1915—Dr. R. H. McGinnis, Jacksonville.
1916—Dr. E. W. Warren, Palatka.
1917—Dr. Ralph N. Greene, Jacksonville.
1918—Dr. F. J. Walton, La Mesa, Cal.
1919—Dr. Wm. E. Ross, Jacksonville.
1920—Dr. W. P. Adamson, Tampa.
1921—Dr. S. R. M. Kennedy, Pensacola.*
1922—Dr. L. M. Anderson, Lake City.
1923—Dr. H. Marshall Taylor, Jacksonville.
1924—Dr. John C. Vinson, Tampa.
1925—Dr. John S. McEwan, Orlando.
1926—Dr. H. Mason Smith, Tampa.
1927—Dr. John A. Simmons, Arcadia.
1928—Dr. F. J. Waas, Jacksonville.
1929—Dr. Henry C. Dozier, Ocala.
1930—Dr. Julius C. Davis, Quincy.
1931—Dr. Gaston H. Edwards, Orlando.*
1932—Dr. Gerry R. Holden, Jacksonville.
1933—Dr. William M. Rowlett, Tampa.
1934—Dr. Homer L. Pearson, Miami.

*Deceased.

Florida Medical Association, Inc.

Officers and Committees

OFFICERS

Homer L. Pearson, M.D., President *Miami*
Herbert L. Bryans, M.D., President-elect *Pensacola*
Robert B. McIver, M.D., First Vice-President . . . *Jacksonville*
Orion O. Feaster, M.D., Second Vice-President . *St. Petersburg*
Robert D. Ferguson, M.D., Third Vice-President *Ocala*
Shaler Richardson, M.D., Secretary-Treasurer . . *Jacksonville*

BUSINESS MANAGER

Stewart G. Thompson, D.P.H. *Jacksonville*

EXECUTIVE

Leland F. Carlton, M.D., Chairman *Tampa*
Leigh F. Robinson, M.D. *Ft. Lauderdale*
Frederick J. Waas, M.D. *Jacksonville*
Homer Pearson, M.D. *Miami*
Shaleb Richardson, M.D. *Jacksonville*
Stewart Thompson, D.P.H. (Advisory) *Jacksonville*

SCIENTIFIC WORK

Gilbert S. Osincup, M.D., Chairman *Orlando*
Louie M. Limbaugh, M.D. *Jacksonville*
Joseph S. Stewart, Jr., M.D. *Miami*

LEGISLATION AND PUBLIC POLICY

Julius C. Davis, M.D., Chairman *Quincy*
Simon E. Driskell, M.D. *Jacksonville*
Corbett E. Tumlin, M.D. *Miami*
James L. Estes, M.D. (Auxiliary Member) *Tampa*
J. Kent Johnston, M.D. (Auxiliary Member) . . . *Tallahassee*
Howard V. Weems, M.D. (Auxiliary Member) *Sebring*

NECROLOGY

Henry E. Palmer, M.D., Chairman, Districts 1, 2, 3, 9, 14, *Tallahassee*
Ferdinand Richards, M.D., District 4 *Jacksonville*
Isaac M. Hay, M.D., Districts 5, 7, 8, 16 *Melbourne*
William G. Post, Jr., M.D., Districts 6, 10, 12, 13, 19, *St. Petersburg*
John D. Milton, M.D., District 11 *Miami*
David R. Kennedy, M.D., District 18 *Sarasota*
Charles J. Collins, M.D., Districts 15, 17, 21 *Orlando*
Harry C. Galey, M.D., District 20 *Key West*

MEDICAL EDUCATION AND HOSPITAL

Harry F. Watt, M.D., Chairman *Ocala*
(Term expires May, 1935)
Haynes Brinson, M.D. *Kissimmee*
(Term expires May, 1937)
Eugene B. Maxwell, M.D. *Miami Beach*
(Term expires May, 1936)

PUBLIC RELATIONS

J. Ralston Wells, M.D., Chairman *Daytona Beach*
(Term expires May, 1935)
John R. Chappell, M.D., Secretary *Orlando*
(Term expires May, 1939)
Hubert A. Barge, M.D. *Miami*
(Term expires May, 1938)
Thomas E. Buckman, M.D. *Jacksonville*
(Term expires May, 1937)
Henry C. Dozier, M.D. *Ocala*
(Term expires May, 1940)
H. Mason Smith, M.D. *Tampa*
(Term expires May, 1936)

PRESIDENT'S ADVISORY

Leonidas M. Anderson, M.D., Chairman *Lake City*
John S. McEwan, M.D. *Orlando*
F. Clifton Moor, M.D. *Tallahassee*

MEDICAL POST-GRADUATE COURSE

Turner Z. Cason, M.D., Chairman *Jacksonville*
Warren Quillian, M.D. *Coral Gables*
William H Spiers, M.D *Orlando*
George C. Tillman, M.D. *Gainesville*

CANCER CONTROL

Gerrt R. Holden, M.D., Chairman *Jacksonville*
(Term expires May, 1938)
Joshua C. Dickinson, M.D. *Tampa*
(Term expires May, 1937)
James M. Hoffman, M.D *Pensacola*
(Term expires May, 1935)
Gerard Raap, M.D. *Miami*
(Term expires May, 1936)
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(Term expires May, 1939)
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AMERICAN MEDICAL ASSN.—HOUSE OF DELEGATES

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(Terms expire after A.M.A. meeting, 1935)
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Gaston H. Edwards, M.D., Alternate *Orlando*
(Terms expire after A.M.A. meeting, 1934)

LEGAL ADVISORS

Marks, Marks, Holt, Gray & Yates
(Address all communications to Box 1018, Jacksonville)



OUR HONOR GUEST,

DR. JAMES E. PAULLIN, ATLANTA

Dr. James E. Paullin of Atlanta will be the Guest of Honor of the Association at its sixty-second annual meeting. Dr. Paullin is well known to the doctors of the South, being Professor of Clinical Medicine at the Emory University School of Medicine. He is president-elect of the Georgia Medical Association; a member of the American Medical Association; the Southern Medical Association; the Association of American Physicians, and the American Clinatological and Clinical Society. He has served as chairman of the Medical Section of the A. M. A. and also of the Southern Medical Association. Dr. Paullin is at present a member of the Scientific Committee of the American Medical Association.

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HOUSE OF DELEGATES

At the last annual meeting, a change was made in Section 3 of Chapter III of the By-Laws, providing an addition to this section as follows: "Ample seating facilities shall be arranged for the House of Delegates, separate and apart from the seating facilities provided for visiting members of the Association." Section 16 is a new section which was added to Chapter III: "Each delegate representing a component society, before being seated, shall deposit with the Association's secretary or his duly authorized representative, a certificate signed by the secretary of his component society, stating that he has been regularly elected a delegate by the component society. All delegates shall report at the registration desk upon arrival at the meeting, exhibit their credentials and receive instructions regarding the meeting place and time of House of Delegates."

One delegate for each twenty members, or major fraction thereof, is allowed each component society as its representation in the House of Delegates. The basis used in determining the number of delegates to which a society is entitled is the number of paid members of that society whose 1935 dues have been paid to the treasurer of the State Association. Members whose dues for 1935 have not been paid cannot be counted in seating delegates. Each society should select its delegate, or delegates, with care as there undoubtedly will be some very important matters brought up before the House of Delegates.

All meetings of the House of Delegates will be held in the Dixie Theatre. The first meeting is scheduled for Monday, May 13, at 8:00 p. m. All delegates will be seated in a reserved space entirely separate from any members who may wish to attend the meeting as visitors.

AMERICAN MEDICAL GOLFERS PLAY IN ATLANTIC CITY, MONDAY, JUNE 10TH

The American Medical Golfing Association will hold its twenty-first annual tournament at the Northfield Country Club in Atlantic City on Monday, June 10, 1935.

Thirty-six holes of golf will be played in competition for the seventy trophies and prizes in the nine events. Trophies will be awarded for the Association Championship, thirty-six holes gross, The Will Walter Trophy; the Association Handicap Championship, thirty-six holes net, The Detroit Trophy; the Championship Flight, First Gross, thirty-six holes, The St. Louis Trophy; the Championship Flight, First Net, thirty-six holes, The President's Trophy; the Eighteen Hole Championship, The Golden State Trophy; the Eighteen Hole Handicap Championship, The Ben Thomas Trophy; the Maturity Event, limited to Fellows over 60 years of age, The Minneapolis Trophy; the Oldguard Championship, limited to competition of past presidents, The Wendell Phillips Trophy; and the Kickers Handicap, The Wisconsin Trophy. Other events and prizes will be announced at the first tee.

ATLANTIC CITY COMMITTEE

The Atlantic City Committee is under the chairmanship of Dr. Walt P. Conaway, 1723 Pacific Ave., Atlantic City. He will be assisted by Drs. I. R. Beir, John Pennington, Alfred Westney, and Rostin White.

APPLICATION FOR MEMBERSHIP

All male Fellows of the American Medical Association are eligible and cordially invited to become members of the A. M. G. A. Write the Executive Secretary, Bill Burns, 4421 Woodward Avenue, Detroit, for an application blank. Participants in the A. M. G. A. tournament are required to furnish their home club handicap, signed by the secretary. No handicap over 25 is allowed, except in the Kickers' (Blind Bogey). Only active members of the A. M. G. A. may compete for prizes. No trophy is awarded a Fellow who is absent from the annual dinner.

GRADUATE SHORT COURSE FOR DOCTORS OF MEDICINE IN FLORIDA

June 24-29, 1935

FACULTY AND LECTURERS

Dr. Fred Lyman Adair, Chicago, Professor of Obstetrics and Gynecology, University of Chicago.

Dr. Oscar Walter Bethea, New Orleans, Professor of Clinical Medicine, Tulane University.

Dr. Horton Casparis, Nashville, Professor of Pediatrics, Vanderbilt University.

Dr. Willis Campbell, Memphis, Professor of Orthopedic Surgery, University of Tennessee.

Dr. Emil Novak, Baltimore, Associate Professor of Obstetrics, University of Maryland.

Dr. Arthur M. Shipley, Baltimore, Professor of Surgery, University of Maryland and Associate Professor of Surgery, Johns Hopkins University

Dr. O. C. Wenger, Hot Springs, Medical Officer in Charge, Hot Springs National Park.

GENERAL INFORMATION

The Graduate Short Course for Doctors of Medicine in Florida will be held at the University of Florida June 24-29. This is the third annual course conducted by the General Extension Division in cooperation with the Florida Medical Association. The program of instruction was arranged by a committee of doctors appointed by the President of the Florida Medical Association. The purpose of the Course is to give the doctors of Florida an opportunity to keep up with the latest discoveries in the field of medical science through direct contact with leading specialists of the country.

REGISTRATION

The committee representing the Florida Medical Association will collect a registration fee of $5. This is the only expense in connection with the course. It is requested that the fee accompany the registration.

Registration cards will be mailed to doctors in the state in due time. It is requested that all doctors who expect to attend the Short Course register in advance in order that adequate accommodations may be arranged.

OTHER EXPENSE

Special rates will be made by the Gainesville hotels. Lodging may be secured near the University campus for $1 per day. The University cafeteria will serve meals for $.80 per day.

INFORMATION DESK

The information desk will be situated in the lobby of the P. K. Yonge Laboratory School.

PROGRAM OF GRADUATE SHORT COURSE, JUNE 24-29, 1935

Hours	Monday, June 24	Tuesday, June 25	Wednesday, June 26	Thursday, June 27	Friday, June 28	Saturday June 29
9:00-10:00	Pediatrics Casparis	Medicine Bethea	Pediatrics Casparis	Gynecology Novak	Gynecology Novak	Surgery Shipley
10:00-11:00	Obstetrics Adair	Obstetrics Adair	Obstetrics Adair	Surgery Shipley	Surgery Shipley	Gynecology Novak
11:00-11:30	Recess	Recess	Recess	Recess	Recess	11:00-12:00 Orthopedic Surgery Campbell
11:30-12:30	Medicine Bethea	Pediatrics Casparis	Medicine Bethea	Orthopedic Surgery Campbell	Orthopedic Surgery Campbell	
12:30- 2:00 Lunch hour Round-table Discussion	Chairman: Casparis	Chairman: Bethea	Chairman: Adair	Chairman: Shipley	Chairman: Novak	12:00- 1:00 Surgery Shipley
2:00- 3:00	Obstetrics Adair	Obstetrics Adair	Venereal Diseases Wenger	Gynecology Novak	Surgery Shipley	
3:00- 3:15	Recess	Recess	Recess	Recess	Recess	
3:15- 4:15	Medicine Bethea	Pediatrics Casparis	Medicine Bethea	Surgery Shipley	Gynecology Novak	
4:15- 5:15	Pediatrics Casparis	Medicine Bethea	Obstetrics Adair	Venereal Diseases Wenger	Venereal Diseases Wenger	
8:00-		Alachua Co. Medical Soc. Smoker: Symposium, Malaria		Lecture on Social Diseases Wenger		

Immediately upon arrival in Gainesville, doctors are requested to report to the information desk where instructions for the week will be given.

LABORATORY AND EXHIBITS

The Florida State Board of Health will set up a model laboratory and give instruction on laboratory technique. There will be exhibits by the Florida Radiological Association on Roentgenology and the Florida Tuberculosis and Health Association on Tuberculosis. Exhibits will be in charge of specialists throughout the week. Two recess periods in each day's program have been set aside during which the doctors may visit the exhibits and enjoy recreation.

BIOGRAPHICAL SKETCHES OF PHYSICIANS GIVING SHORT COURSE*

Dr. Oscar W. Bethea

Dr. Oscar W. Bethea was born in South Carolina in 1878. Following the prevailing custom of those expecting to enter medicine, he started to work in a retail drug store at an early age. He graduated in pharmacy in 1901 and practiced the profession for several years. In 1906 he became Professor of Pharmacology in the Mississippi Medical College; in 1907 he became Professor of Pharmacology and of Chemistry. In 1911 he graduated from the Medical Department of Tulane University and has been practicing in New Orleans since that time. During the latter half of this period he has confined his work to internal medicine.

Dr. Bethea is now Professor of Clinical Medicine in the Undergraduate, and Professor of Therapeutics in the Postgraduate Departments of Tulane. He is head of the Department of Medicine at the Southern Baptist Hospital and a Senior Visiting Physician and President of the staff at the great Charity Hospital at New Orleans. He is a member of the revision committee of the United States Pharmacopeia. Dr. Bethea is a fellow of the American College of Physicians, of The Chemical Society (Great Britain), and fellow or member of various local, state and national medical organizations. He is President of the American Therapeutic Society. Last year Doctor Bethea made the commencement oration at the Philadelphia College of Pharmacy and Science and received the honorary degree of Master of Pharmacy.

In 1915 he published "Materia Medica and Prescription Writing" which is now going into its fifth edition. His book, "Clinical Medicine," is now being revised for the second edition. He has contributed various papers, many of which covered original work especially new instruments and new diagnostic measures.

Dr. O. C. Wenger

Dr. O. C. Wenger, Medical Officer in Charge Hot Springs National Park, Arkansas, who presented the course in Venereal Diseases last June, will return this year to give further lectures on this subject.

Dr. Wenger graduated from St. Louis University in 1908. Following his internship at St. Louis Female Hospital, he became assistant at the Medical Clinic, Alexian Brothers Hospital in St. Louis, where he remained until 1910. In 1910 he joined the Department of Communicable Diseases, St. Louis Health Department. From 1912 to 1915 he was Medical Inspector, Philippine Constabulary. After two more years with the St. Louis Health Department, he joined the army in 1917. Since 1919 he has been with the United States Public Health Service, Division of Venereal Diseases, having become director of the United States Public Health Service Venereal Diseases Clinic at Hot Springs in November, 1921.

*Biographical sketches of other faculty members will appear in the May Journal.

ACTION OF EXECUTIVE COMMITTEE FOLLOWING SPECIAL SESSION HOUSE OF DELEGATES, A. M. A

Pursuant to the Special Session House of Delegates of the American Medical Association held in Chicago, February 15 and 16, 1935, the Florida Medical Association concur in the support of the report of the Reference Committee, copy of which is attached.

The report of the Reference Committee as approved by the American Medical Association is also approved by the Florida Medical Association as a general plan of procedure. But for the best interest of the patient, the hospital and the profession in general, it is the desire of this State Association that we disapprove for the State of Florida any proposed form of insurance for the purpose of defraying either hospital or medical expenses.

Lay control, as provided in the various plans of hospital and medical insurance, especially pertaining to medical management is very objec-

tionable. Experience has shown that it has not proven to the best interest for the welfare of the people in the preservation of health and that it will necessarily retard the advancement of medical science.

Therefore, it is the consensus of opinion of the Executive Committee of and for the State Medical Association that the Society as a whole do not approve any plan for hospital or medical insurance for the State of Florida.

FLORIDA MEDICAL ASSN.
Executive Committee:
LELAND F. CARLTON, M.D.,
Chairman;
LEIGH F. ROBINSON, M.D.,
FREDERICK J. WAAS, M.D.,
HOMER PEARSON, M.D.,
SHALER RICHARDSON, M.D.

AMERICAN MEDICAL ASSN.
House of Delegates:
BUNDY ALLEN, M.D.,
MEREDITH MALLORY, M.D.

REPORT OF THE REFERENCE COMMITTEE SPECIAL SESSION HOUSE OF DELEGATES

February 15 and 16, 1935.

Your reference committee, believing that regimentation of the medical profession and lay control of medical practice will be fatal to medical progress and inevitably lower the quality of medical service now available to the American people, condemns unreservedly all propaganda, legislation or political manipulation leading to these ends.

Your reference committee has given careful consideration to the record by the Board of Trustees of the previous actions of this House of Delegates concerning sickness insurance and organized medical care and to the account of the measures taken by the Board of Trustees and the officials of the Association to present this point of view to the government and to the people.

The American Medical Association, embracing in its membership some 100,000 of the physicians of the United States, is by far the largest medical organization in this country. The House of Delegates would point out that the American Medical Association is the only medical organization open to all reputable physicians and established on truly democratic principles, and that this House of Delegates, as constituted, is the only body truly representative of the medical profession.

The House of Delegates commends the Board of Trustees and the officers of the Association for their efforts in presenting correctly, maintaining and promoting the policies and principles, heretofore established by this body.

The primary considerations of the physicians constituting the American Medical Association are the welfare of the people, the preservation of their health and their care in sickness, the advancement of medical science, the improvement of medical care, and the provision of adequate medical service to all the people. These physicians are the only body in the United States qualified by experience and training to guide and suitably control plans for the provision of medical care. The fact that the quality of medical service to the people of the United States today is better than that of any other country in the world is evidence of the extent to which the American medical profession has fulfilled its obligations.

The House of Delegates of the American Medical Association reaffirms its opposition to all forms of compulsory sickness insurance whether administered by the Federal government, the governments of the individual states or by any individual industry, community or similar body. It reaffirms, also, its encouragement to local medical organizations to establish plans for the provision of adequate medical service for all of the people, adjusted to present economic conditions, by voluntary budgeting to meet the costs of illness.

The medical profession has given of its utmost to the American people, not only in this but in every previous emergency. It has never required compulsion but has always volunteered its services in anticipation of their need.

The Committee on Economic Security, appointed by the President of the United States, presented in a preliminary report to Congress on January 17 eleven principles which that Committee considered fundamental to a proposed plan of compulsory health insurance. The House of Delegates is glad to recognize that some of the fundamental considerations for an adequate, reliable and safe medical service established by the medical profession through years of experi-

ence in medical practice are found by the Committee to be essential to its own plans.

However, so many inconsistencies and incompatabilities are apparent in the report of the President's Committee on Economic Security thus far presented that many more facts and details are necessary for a proper consideration.

The House of Delegates recognizes the necessity under conditions of emergency for federal aid in meeting basic needs of the indigent; it deprecates, however, any provision whereby federal subsidies for medical services are administered and controlled by a lay bureau. While the desirability of adequate medical service for crippled children and for the preservation of child and maternal health is beyond question, the House of Delegates deplores and protests those sections of the Wagner Bill which place in the Children's Bureau of the Department of Labor the responsibility for the administration of funds for these purposes.

The House of Delegates condemns as pernicious that section of the Wagner Bill which creates a social insurance board without specification of the character of its personnel to administer functions essentially medical in character and demanding technical knowledge not available to those without medical training.

The so-called Epstein Bill, proposed by the American Association for Social Security now being promoted with propaganda in the individual states, is a vicious, deceptive, dangerous and demoralizing measure. An analysis of this proposed law has been published by the American Medical Association. It introduces such hazardous principles as multiple taxation, inordinate costs, extravagant administration and an inevitable trend toward social and financial bankruptcy.

The committee has studied this matter from a broad standpoint, considering many plans submitted by the Bureau of Medical Economics as well as those conveyed in resolutions from the floor of the House of Delegates. It reiterates the fact that there is no model plan which is a cure-all for the social ills any more than there is a panacea for the physical ills that affect mankind. There are now more than 150 plans for medical service undergoing study and trial in various communities in the United States. Your Bureau of Medical Economics has studied these plans and is now ready and willing to advise medical societies in the creation and operation of such plans. The plans developed by the Bureau of Medical Economics will serve the people of the community in the prevention of disease, the maintenance of health and with curative care in illness. They must at the same time meet apparent economic factors and protect the public welfare by safeguarding to the medical profession the functions of control of medical standards and the continued advancement of medical educational requirements. They must not destroy that initiative which is vital to the highest type of medical service.

In the establishment of all such plans, county medical societies must be guided by the ten fundamental principles adopted by this House of Delegates at the annual session in June, 1934. The House of Delegates (see Journal A. M. A., June 30, 1934, page 2200) would again emphasize particularly the necessity for separate provision for hospital facilities and the physician's services. Payment for medical service, whether by prepayment plans, installment purchase or so-called voluntary hospital insurance plans, must hold, as absolutely distinct, remuneration for hospital care on the one hand and the individual, personal, scientific ministrations of the physician on the other.

Your Reference Committee suggests that the Board of Trustees request the Bureau of Medical Economics to study further the plans now existing and such as may develop, with special reference to the way in which they meet the needs of their communities, to the costs of operation, to the quality of service rendered, the effects of such service on the medical profession, the applicability to rural, village, urban and industrial population, and to develop for presentation at the meeting of the American Medical Association in June model skeleton plans adapted to the needs of populations of various types.

(Signed) Dr. Harry H. Wilson, Chairman, California.
Dr. Warren F. Draper, Virginia.
Dr. E. F. Cody, Massachusetts.
Dr. E. H. Carey, Texas.
Dr. N. B. Van Etten, New York.
Dr. F. S. Crockett, Indiana.
Dr. W. F. Braasch, Minnesota.

STATE NEWS ITEMS

Dr. Homer Pearson, president, has announced the appointment of Dr. E. B. Maxwell of Miami Beach to the Committee on Hospitals and Medical Education. Dr. Harry F. Watt, a member of that Committee, has been made chairman to fill the unexpired term of Dr. R. C. Woodard, who has resigned.

* * *

Dr. T. H. Dillard of DeLand has temporarily closed his offices on account of ill health. His many friends wish for him a speedy recovery.

* * *

Dr. A. B. Quasser of Jacksonville announces the removal of his office to 352 St. James Building.

* * *

Dr. Julius T. Westermann of Miami died suddenly, January 27, while attending a meeting of the Florida Crippled Children's Association in Tampa.

* * *

The many friends of Dr. Shaler Richardson, secretary-treasurer of the Association, extend to him their deepest sympathy in the loss of his wife, Helen Hare Richardson. Mrs. Richardson died on March 25 in Jacksonville.

* * *

Dr. E. E. Strickland, formerly of Citra, has opened offices in Mount Dora.

* * *

Dr. John J. Kindred of DeLand has lately been elected president of the National Association of Private Psychiatric Hospitals.

* * *

Dr. J. A. Newnham, formerly of Stuart but who has spent some time recently in New York, has opened offices in the Harvey Building, West Palm Beach.

* * *

The many friends of E. W. Warren of Palatka will regret to learn that he suffered a mild attack of apoplexy in January and is at present disabled. His general health, however, is splendid and he anticipates an early recovery.

* * *

Dr. T. F. Hahn, formerly of Crescent City, has opened offices in the Dreka Building, DeLand.

HORACE LEE SIMPSON, M. D.

Dr. Horace Lee Simpson, one of Pensacola's leading physicians, died after a few days' illness, February 4, 1935, at his home, No. 20 W. Belmont St.

He was born February 10, 1863, in Andalusia, Ala., and had practiced his profession in Pensacola forty-six years.

He was a graduate of Yale University and received his medical degree from the New York College of Physicians and Surgeons and later was an interne in Bellevue Hospital, New York City.

He held many responsible positions, among them being a member of the Florida State Board of Health: membership in the First District, Board of Medical Examiners; member of the U. S. Pension Board of Medical Examiners, and City Physician of Pensacola. He was also a member of the Escambia County Medical Society, the Florida State Medical Association, and American Medical Association.

He was a consistent member and an official of the First Presbyterian church.

The following resolution was adopted by the Escambia County Medical Society, in regular session.

"*Whereas*, God in His infinite wisdom hath seen fit to remove from our midst one of our most beloved brothers, Dr. Horace Lee Simpson, and

"*Whereas*, by his untiring devotion to the practice of medicine, and his sacrifices in the interests of charity, he endeared himself to the entire community, and,

"*Whereas*, we, the members of the Escambia County Medical Society, feel deeply the loss of our beloved brother and friend; therefore be it,

"*Resolved*, that the Escambia County Medical Society expresses its sorrow in the passing of Dr. Horace Lee Simpson: that a copy of this resolution be sent to his widow: that a copy be entered on the minutes of this society: and that the same be published in the Journal of the Florida Medical Association.

J. H. Pierpont,
A. M. Ames,
Herbert L. Bryans,
Committee.

Pensacola, Fla., March 20, 1935."

Dr. Lewis W. Glatzau of Daytona Beach will attend the Spring Graduate Course at Gill Memorial Eye, Ear and Throat Hospital, Roanoke, Virginia. From there, he will visit clinics in his line of work in Washington, D. C., Boston, and Philadelphia. He expects to be away about two weeks.

* * *

Dr. G. A. Davis, president of the Volusia County Medical Society, is wearing a new Stetson derby recently presented to him by the John B. Stetson Company. Dr. Davis is past 76 years of age and is enjoying a splendid practice.

FOR SALE—Victor X-ray, hospital size, 1922 model. Buckeye extension, developing equipment. Operating table, instrument table, gas dry goods and instrument sterilizer. Complete set abdominal surgical instruments. Any reasonable price accepted. Mrs. C. C. Bohannon, 154 First Avenue, Daytona Beach.

WANTED—Drug or Detail Salesman calling regularly on dispensing physicians, free to accept non-competing line. Liberal commission and full protection. Give present line, territory covered, and number of trips per year. Complete cooperation and direct mail assistance. Gaston Moreau, 509 Fifth Avenue, New York, N. Y.

COMPONENT COUNTY SOCIETIES

DADE COUNTY MEDICAL SOCIETY

The regular meeting of the Dade County Medical Society was held in the Huntington Club Rooms, Miami, April 5 at 8:30 p. m. The following scientific papers constituted the program:

"A Comparison of Disease Incidence in Iowa and Florida with Special Reference to the Effect of Climate Upon the Incidence of Digestive Disease", P. B. Welch.

"Skull Injuries", H. Hamilton Cooke.

DE SOTO-HARDEE-HIGHLANDS COUNTY MEDICAL SOCIETY

THE DeSOTO-HARDEE-HIGHLANDS COUNTY MEDICAL SOCIETY IS 100% PAID FOR 1935. TWO NEW MEMBERS HAVE BEEN REPORTED BY THIS SOCIETY. OFFICERS SERVING FOR 1935 ARE:

President—C. H. KIRKPATRICK, ARCADIA.
Vice-Pres.—B. D. SPEARS, WAUCHULA
Sec'y-Treas.—L. W. MARTIN, SEBRING.

DR. W. H. PEACOCK OF WAUCHULA WILL SERVE AS DELEGATE TO THE ANNUAL MEETING WITH DR. L. W. MARTIN, ALTERNATE DELEGATE.

HILLSBORO COUNTY MEDICAL SOCIETY

The following officers are serving the Hillsboro County Medical Society for 1935:

President—G. C. Bottari.
Vice-President—William C. Blake.
Sec'y-Treas.—John S. Helms, Jr.
Delegates to State Convention—Bundy Allen, J. W. Taylor, W. M. Rowlett, W. P. Adamson and J. W. Alsobrook.

That the Hillsboro County Medical Society is functioning in an active manner is evidenced by the fact that twelve new and reinstated members have been added to the roster for 1935.

LAKE COUNTY MEDICAL SOCIETY

A meeting of the Lake County Medical Society was held in Eustis on March 6. Dr. Will Wood of Mount Dora and Dr. W. G. Devane, Groveland, read papers.

MADISON COUNTY MEDICAL SOCIETY

THE MADISON COUNTY MEDICAL SOCIETY, SMALLEST SOCIETY OF THE STATE ORGANIZATION, HAS PAID 100% OF MEMBERSHIP DUES FOR 1935. ONE NEW MEMBER HAS BEEN ADDED TO THE SOCIETY THIS YEAR.

PALM BEACH COUNTY MEDICAL SOCIETY

THE PALM BEACH COUNTY MEDICAL SOCIETY BECOMES THE FIRST OF THE LARGE SOCIETIES TO PAY 100% DUES FOR 1935. THIS SOCIETY HAS A PAID MEMBERSHIP OF FIFTY-TWO, THREE OF WHICH ARE NEW MEMBERS. THIS SOCIETY IS TO BE CONGRATULATED ON ITS ACHIEVEMENT.

PASCO-HERNANDO-CITRUS COUNTY MEDICAL SOCIETY

THE PASCO-HERNANDO-CITRUS COUNTY MEDICAL SOCIETY IS 100% PAID FOR 1935. THIS IS A REAL ACHIEVEMENT AS IT WAS NECESSARY TO COLLECT DUES FROM DOCTORS LIVING IN SEVEN CITIES SCATTERED THROUGH THESE THREE COUNTIES. CONGRATULATIONS!

The monthly meeting of the Pasco-Hernando-Citrus County Medical Society was held March

14 at Dade City, with Dr. J. T. Bradshaw, host. The meeting was devoted mainly to problems of medical legislation. Senator F. L. Touchton and Representative J. B. Burks were honor guests, Eight members were present.

PINELLAS COUNTY MEDICAL SOCIETY

On March 25 a joint meeting of the St. Petersburg Dental Society and the Pinellas County Medical Society was held. The purpose of the meeting was to discuss proposed legislation on State medicine and dentistry.

Dr. W. C. McConnell of Pinellas County is an unusually successful treasurer. He manages to make his monetary extractions less painful by the use of anesthesia in the form of humor. That his methods are successful is evidenced by the fact that the Pinellas County Society is dependably a 100% paid society early each year. The following announcement of a meeting is reproduced to show how graphically he "gets away" with his job this year:

PINELLAS COUNTY MEDICAL SOCIETY, INC., WILL MEET MARCH 1, 1935, AT 8 P. M. IN THE POWER & LIGHT BUILDING

Treatment of Eclampsia—Wright.
The Application of Psychiatry to School and Business—McConnell.
Discussion opened by Moore & Gates.
Marr—Program Chairman.

Proposed Amendment: Add words "and assessments" after word "dues" in ARTICLE V, SECTIONS 5 & 6 of By-Laws.

HARDEN—PRESIDENT FEASTER—SECRETARY



State Dues are delinquent after April 10th

"Damn that Treasurer!"

$ will appease him.

Well worth mentioning are the desk blotters which have been distributed by the Pinellas County Medical Society to its membership. On this desk blotter is printed the time and date of the monthly medical society meeting; the time and date of hospital staff meetings; and hospital telephone numbers. The treasurer has his alligator cut near the bottom as a wordless reminder that he is looking for a check.

ST. JOHNS COUNTY MEDICAL SOCIETY

THE ST. JOHNS COUNTY MEDICAL SOCIETY HAS REPORTED 100% DUES FOR 1935. THIS BECOMES THE ELEVENTH SOCIETY TO BE PLACED ON THE HONOR ROLL THIS YEAR. THE OFFICERS OF THE SOCIETY ARE:
President—REDDIN BRITT.
Vice-Pres.—CHARLES C. GRACE.
Secretary—JOHN L. BENNETT.
Treasurer—WALTER G. POTTER.
Delegate—H. E. WHITE.
Alternate—A. C. WALKUP.

SEMINOLE COUNTY MEDICAL SOCIETY

THE SEMINOLE COUNTY MEDICAL SOCIETY IS 100% PAID FOR 1935. THE OFFICERS WHO ARE DIRECTING THE ACTIVITIES OF THIS SOCIETY ARE:
President—C. L. PARK, SANFORD.
Vice-President—C. M. MITCHELL, SANFORD.
Sec'y-Treasurer—JOHN T. DENTON, SANFORD.

DR. H. D. SMITH OF SANFORD WILL SERVE AS DELEGATE TO THE NEXT STATE MEETING.

SUMTER COUNTY MEDICAL SOCIETY

THE SUMTER COUNTY MEDICAL SOCIETY HAS STEPPED FORWARD. THIS SOCIETY, WHICH HAS HAD A MEMBERSHIP OF ONLY THREE DOCTORS FOR SEVERAL YEARS, HAS ADDED TWO NEW MEMBERS. THEY ALL PAID THEIR DUES FOR 1935.

A number of years ago, Dr. W. E. Mitchell of Coleman, who serves as secretary-treasurer of the Sumter County Medical Society, was notified that the Executive Committee had taken action, exempting all county society secretaries from paying State Association dues. Doctor Mitchell replied that he did not think it would be fair to take advantage of his exemption inasmuch as the society was a small one and the other members paid dues. He has, therefore, continued to serve his society and the State Association without remuneration of any kind. The Association commends Dr. Mitchell for his unselfish attitude.

CONVENTION NOTES

SCIENTIFIC PROGRAM

There will be only eleven papers presented during the scientific assemblies. Your Committee on Scientific Work has reduced the number of papers in order that more time may be allowed for discussions. The subject matter and essayists were very carefully selected by your Committee and it is hoped that those present will take part in the discussion of the various papers.

HEADQUARTERS HOTEL

The local Committee on Arrangements has designated the Hotel Marion as headquarters for the annual meeting, May 13, 14, and 15. The registration desk as well as exhibit booths will be located in the lobby of this hotel. The Association dinner will also be held in the headquarters hotel, Tuesday evening.

DIXIE THEATRE

All general sessions, scientific programs and meetings of the House of Delegates will be held in the Dixie Theatre. This theatre is located about two blocks from the headquarters hotel.

ALUMNI AND FRATERNITY GATHERINGS

Representatives of alumni and fraternity groups who contemplate get-together meetings or luncheons at the State Convention in Ocala are requested to make their wishes known as soon as possible. Arrangements will be made for meeting places for all such groups, provided sufficient notice is given to the Chairman of the local committee. It is necessary to arrange these group meetings so they will not conflict with the program of the State Association. Tuesday noon (May 14), has in the past been considered the ideal time. However, if this particular day is not convenient for any group, your Committee will arrange such meeting for Monday noon, May 13. Your Committee also requests information as to the approximate number who will be expected to attend each group meeting. Communications relative to Alumni and Fraternity group meetings should be addressed to Dr. Harry F. Watt, Chairman, Ocala.

GOLF

The golf tournament will be held at the Ocala Highlands Club, Tuesday, May 14. A complete announcement of this tournament is given in the Entertainment Program which appears elsewhere in this Journal.

Reservations may be made at the Ocala Highlands Hotel by those who play golf. There will be accommodations for about fifty at this hotel, which is located on the golf links. Since the accommodations are so limited, you are requested to make your reservations as early as possible.

* * *

The regular quarterly meeting of the Florida Society of Dermatology and Syphilology will be held Monday, May 13, in Ocala. There will be a luncheon at 12:30 p. m. at the Marion Hotel on the above date. Election of officers, a business meeting and a clinical session will follow.

* * *

The Emory University Alumni luncheon will be held at noon, Tuesday, May 14, in Ocala.

* * *

There will be a meeting of the Fellows of the Southeastern Surgical Congress on Monday, May 13, at 6:00 p. m. This meeting will be held in a private dining room at the Harrington Hall Hotel.

* * *

The Phi Beta Pi Medical Fraternity will hold its annual meeting Tuesday, May 14, at the Florida Medical Convention in Ocala. Drs. Harry F. Watt and Richard C. Cumming of Ocala will be in charge of Arrangements, assisted by Drs. T. E. McBride of Apopka, H. M. Merchant of Gainesville, J. H. Rutter of Daytona Beach and A. T. Cobb, Jr., of Raiford. Dr. H. A. Barge of Miami will serve as toastmaster and Col. George C. Johnston will be the principal speaker. Drs. Homer L. Pearson and Roy J. Holmes of Miami, O. O. Feaster of St. Petersburg, John S. McEwan and C. D. Christ of Orlando, Shaler Richardson of Jacksonville and Vernon A. Lockwood of St. Augustine will make short talks. A large turnout is expected.

* * *

There will be a meeting of the Florida Radiological Society on Monday morning, May 13, at 10:00 a. m. at the Harrington Hall Hotel. This meeting will be in advance of the regular program scheduled by the Florida Medical Association in Ocala.

* * *

All those wishing to attend a medical fraternity or alumni luncheon on Tuesday, May 14, at 12:30, please notify Dr. H. F. Watt of Ocala, as soon as possible, stating name of your fraternity or alumni.

WOMAN'S AUXILIARY

TO THE
FLORIDA MEDICAL ASSOCIATION, INC.

State Editor
MRS. S. M. COPELAND
1356 Willawbranch Ave.,
Jacksonville, Florida

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Dear Women of the State Medical Association:

The annual meeting of the State Medical Auxiliary will be held in Ocala, May 13th and 14th. All doctors' wives, daughters and mothers are most cordially invited to attend this meeting.

On another page of this Journal you may read the program and see what delightful social events have been planned by the hostess ladies for our pleasure and entertainment.

One charming feature will be a luncheon at beautiful Silver Springs, one of the most noted of Florida's many attractions. This will be followed by a glass-bottomed boat trip over the Springs.

On Tuesday morning, May 14th, at 9:30, there will be held a business meeting in the Hotel Marion. All guests are invited to attend this meeting, as well as all social affairs, whether Auxiliary Members or not. Attending all appointments of a convention affords such a splendid opportunity of meeting new people and of becoming better acquainted with others we know but slightly. It is the best way to fulfill one of the prime objects of Auxiliary, "To promote acquaintanceship among physicians' families that fellowship may increase."

I am looking forward with great pleasure toward seeing and meeting a large delegation of you in Ocala.

Sincerely,
MRS. E. R. MCMURRAY, *President.*

* * *

DADE COUNTY AUXILIARY

The Woman's Auxiliary to the Dade County Medical Society met February 11th at the home of Mrs. Duncan Owens, Pine Tree Drive, Miami Beach. A covered dish luncheon was served. Mrs. Robert C. Booth rendered several readings. Mrs. W. W. Owens of Savannah, Georgia, and Mrs. D. VonLackum of Cedar Rapids, Iowa, were guests. Mrs. H. A. Leavitt, president, presided at the meeting.

* * *

PINELLAS COUNTY AUXILIARY

An interesting meeting of the Pinellas County Medical Society Auxiliary was held recently at the Yacht Club, when the monthly luncheon was held. Mrs. O. O. Feaster, vice-president, presided in the absence of Mrs. W. W. Harden, president. Mrs. J. Braden Quicksall read an interesting paper and Mrs. Raymond Keith O'Brien sang three selections, accompanied by Mrs. A. D. Glascock. Guests were Mesdames Hugh Scott, Percival Hall, E. Russell and John A. Norpell.

* * *

DUVAL COUNTY AUXILIARY

The Woman's Auxiliary to the Duval County Medical Society met recently in the home of Mrs. Theodore G. Croft, with Mrs. G. R. Holden. Mrs. A. K. Wilson, Mrs. Frederick G. Waas and Mrs. S. M. Copeland acting as co-hostesses Mrs. Gordon H. Ira, President, presided.



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The following nominating committee was appointed: Mrs. S. M. Copeland, Mrs. H. R. Drew, Mrs. L. Y. Dyrenforth, who will give their report at the June meeting, when new officers will be elected.

Mrs. A. K. Wilson, program chairman, introduced Dr. E. T. Sellers, president of the Duval County Medical Society, who gave an interesting short talk and who, in turn introduced Dr. Eugene G. Peek of Ocala, who spoke to the Auxiliary on Preventive Medicine.

After Dr. Peek concluded his talk, Mrs. Peek consented to tell the members a few interesting facts about her auxiliary in Ocala.

At the conclusion of the program, the guests were invited to assemble in the dining room, where a delightful tea was served. The beautifully appointed table was overlaid with a handmade cloth, and centered with a bowl of dainty plum blossoms and green fern. Lending to the decorative effect was the soft glow of many white candles burning throughout the room. The spacious rooms were decorated throughout with bouquets of plum blossoms and green fern. Pouring tea was Mrs. S. M. Copeland and the coffee urn was presided over by Mrs. G. R. Holden.

* * *

Women Attending Southeastern Surgical Congress Entertained.

The wives of surgeons attending the Southeastern Surgical Congress at Jacksonville recently were entertained at a delightful luncheon in the Florida Yacht Club, given by the committee of local women, together with officers of the Woman's Auxiliary to the Duval County Medical Association. Mrs. Frederick J. Waas, chairman of the committee on entertainment, presided at the informal luncheon and introduced members of her committee to the visitors. The affair proved wholly delightful. The table was decorated with arrangements of pastel shaded snapdragons and fern.

Another feature of the entertainment provided for the visiting wives of doctors, was a "microbe party" held in the parlors of the George Washington Hotel. The novel entertainment was planned by Mrs. Frederick J. Waas, chairman of the hostess committee. Card tables were placed and each player was given a score sheet on which she was asked to draw the figure indicated by the die she cast. Much merriment was caused in the resulting drawings. Prizes were won by Mrs. J. R. Young of Anderson, S. C., Mrs. B. G. Beasley of Atlanta, and Mrs. Ellis S. Allen of Louisville, Ky., all receiving copies of the book "Mrs. Dose, the Doctor's Wife." Mrs. Waas was assisted in serving dainty refreshments by her committee, Mrs. Gerry R. Holden, Mrs. William S. Manning, Mrs. Edward Jelks, Mrs. Shaler Richardson, Mrs. Marshall Taylor, Mrs. Knox Simpson, Mrs. E. T. Sellers, Mrs. J. Lyerly and Mrs. James H. Hartman.

A very delightful entertainment was offered the wives of surgeons attending the Southeastern Surgical Congress on Tuesday afternoon when a tea was given at Ponte Vedra Club. Mrs. Frederick J. Waas and her very able committee were responsible for the arrangements. Cars were offered generously by a local dealer and conveyed the visitors down to the beach. Tea was served in the lovely sun parlor, Mrs. Gerry R. Holden and Mrs. William S. Manning pouring. The table was lovely with a variety of spring flowers and even the inclement weather could not mar the delightful afternoon, which was enjoyed by about 60 wives of visiting surgeons.

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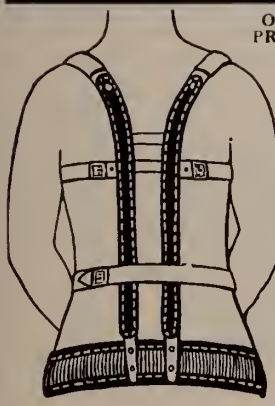
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Advances in Ovarian Therapy

A gynecologist, whose name is known from coast to coast, recently commented in the Journal of the American Medical Association (Feb. 23rd) about the cost of ovarian therapy: "It is greatly regretted," he wrote, "that the American products have not been available at prices that justify their preference or at least their being on a parity with the imported material."

Physicians who have read this statement will be interested in the announcement from the Squibb Laboratories that the potency of Amniotin—a physiologically tested preparation of the ovarian follicular hormone, has been increased three-fold and the cost per unit has been reduced to about one-tenth of its former price. For hypodermic administration, Amniotin in oil is now distributed in 1 cc. size ampuls, containing 8000 and 2000 International Units per cc.

Amniotin Capsules and Pessaries (vaginal suppositories) now contain 1000 and 2000 International Units, respectively. The price of these packages is now so low as to compare favorably with the cost of insulin.

These new high-potency preparations should make ovarian hormone (estrin) therapy eminently more satisfactory. Amniotin in indicated in the treatment of menopausal symptoms; involutional me'ancholia; gonorrheal vaginitis in children; senile vaginitis; breast hyperplasia (lobular type associated with bleeding); selected cases of frigidity, and migraine of pituitary origin.

Cigarette Smoke

Michael S. Mulinos and Raymond L. Osborne. Pharmacology of Inflammation: III. Influence of Hygroscopic Agents on Irritation from Cigarette Smoke. Proc. Soc. Exp. Biol. & Med., 1934, 32, 341-245. A successful attempt to measure objectively the irritant properties in cigarette smoke is reported. The method used was that

CIGARETTE SMOKE
not necessarily a cause of IRRITATION

CONGESTION of the pharynx and larynx caused or accentuated by smoke from cigarettes in which glycerine was used as the hygroscopic agent showed improvement in all cases when cigarettes using diethylene-glycol as hygroscopic agent were smoked.

Some Clinical Observations on the Influence of certain Hygroscopic Agents in Cigarettes.
Laryngoscope, 1935, XLV, 149-154★

SEE ALSO
Pharmacology of Inflammation: III. Influence of hygroscopic agents on irritation from cigarette smoke.
Proc. Soc. Exp. Biol. and Med., 1934, 32, 241-245★

The results reported in these papers find a practical application in Philip Morris cigarettes, in which only diethylene-glycol is used as the hygroscopic agent. To any Doctor who wishes them for himself, the Philip Morris Company will gladly mail a sufficient sample on request below. ★★

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★ Reprint of papers from Laryngoscope 1935 XLV, 149-154 and from Proc. Soc. Exp. Biol. and Med., 1934, 32, 241-245. ☐

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described by Hirschhorn and Mulinos: Proc. Soc. Exp. Biol. & Med., 1930, 28, 168. A study of the influence of hygroscopic agents on the edema produced on the conjunctive of rabbits is given. The hygroscopic agents most commonly used in cigarettes are glycerine and diethylene glycol. It was stated that, "It is obvious that the cigarettes which have been made with diethylene glycol as hygroscopic agent prove to be less irritating than those with glycerine." Not only was the irritation greater in the case of glycerine than from diethylene glycol, but it lasted a longer time. It is further stated that "The edema produced by the smoke solution from the untreated cigarette lasted an average of 31 minutes (8-82); that from the diethylene glycol lasted 8 minutes (0-21); and that with the glycerine lasted 45 minutes (17-122.)"

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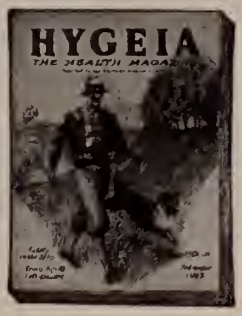
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Summary of March Issue Borden Abstracts

Evaporated milk, according to Abstract No. 29, is a safe and economical milk, the use of which will eliminate the risk of milk-borne infections, especially when it is acidified with lactic acid. Acidification of evaporated milk with lemon juice is recommended in the article outlined in Abstract No. 30.

Control of rickets with vitamin D milk containing 50 units of vitamin D is reported in Abstract No. 31. The value of vitamin D milk as a prophylactic of infantile rickets is discussed also in Abstracts Nos. 32, 33, and 34.

The protein of milk is more valuable in human nutrition than any other protein, including that of meat, as shown by the study reviewed in Abstract No. 35. This investigation also brings out the facts that pasteurization does not alter the nutritional qualities of milk, and that milk in the diet prevents fatigue.

The economy and dietary excellence of milk for human consumption are emphasized in Abstracts Nos. 36 and 37.

Simplification of infant feeding, with due regard to appetite demands, is stressed in the paper mentioned in Abstract No. 38, in which the convenience and cleanliness of the dried milks are brought out. A decade of progress in infant feeding is reviewed in the article which is the basis of Abstract No. 39. Here again, the significance of dried, evaporated, and condensed milks is pointed out.

Two new books of interest are reviewed in Abstracts Nos. 40 and 41.

Please give yourself this good advice, Doctor



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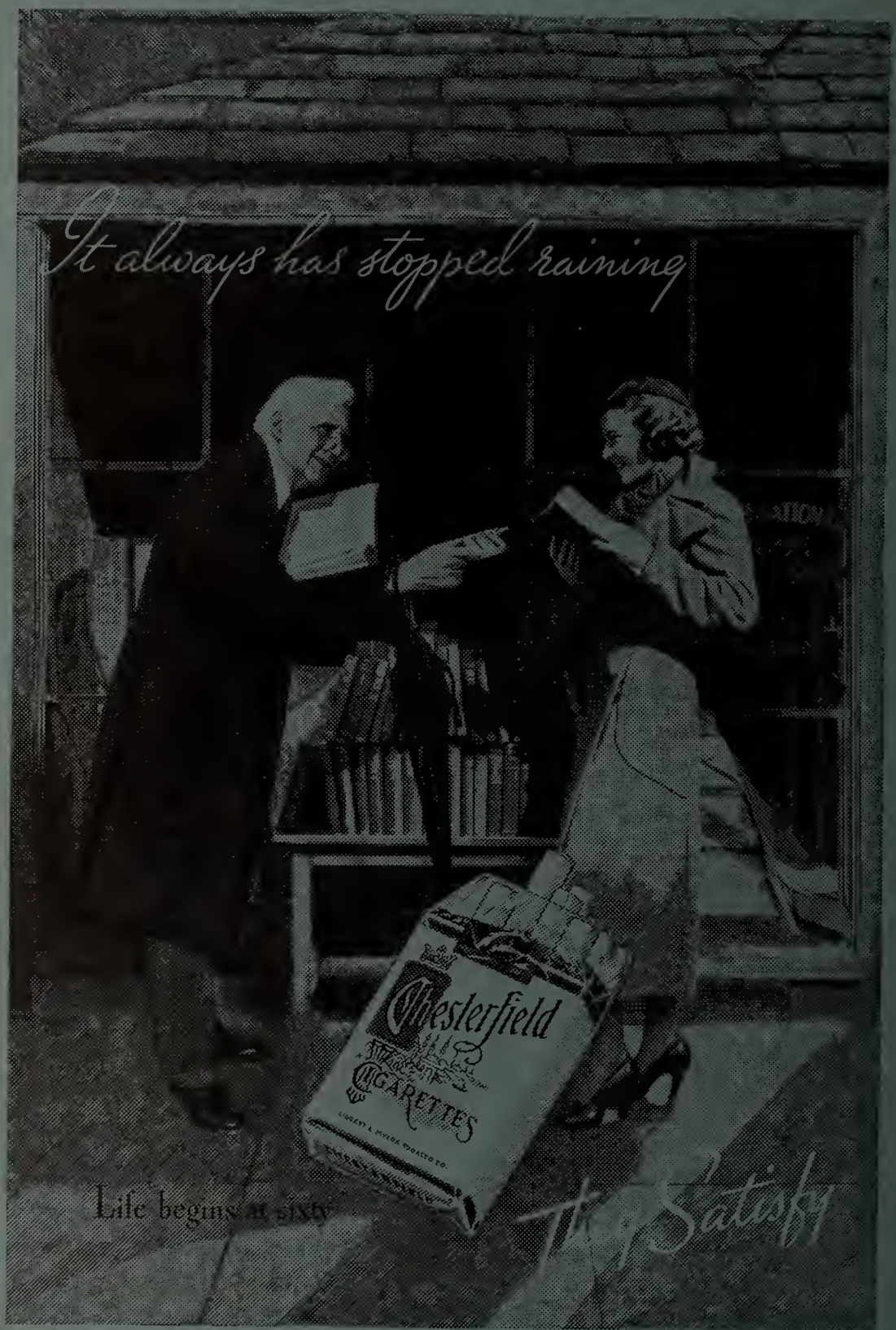
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		Date	Time	Place	Luncheon?	
Alachua	Harry M. Merchant, M.D., Gainesville.	2nd Tuesday	12:00 Noon	White House Gainesville	Yes.	85%
Bay	Allen H. Miller, M.D., Millville.					73%
Brevard	Bob Schlernitzauer, M.D., Rockledge.	2nd Tuesday		Varies	Yes.	36%
Broward	Robert E. Blount, M.D., Ft. Lauderdale.	Last Wednesday.	8:00 P.M.	Elks' Hall Ft. Lauderdale	No.	95%
Columbia	T. H. Bates, M.D., Lake City.	1st Monday	7:30 P.M.	Blanche Hotel Lake City		100%
Dade	Robert T. Spicer, M.D., Miami.	1st Friday	8:30 P.M.	Club Room Huntington Bldg. Miami	Occasionally.	63%
DeSoto-Hardee-Highlands	L. W. Martin, M.D., Sebring.	2nd Tuesday	8:00 P.M.	Varies	Yes.	100%
Duval	Charles B. Mabry, M.D., Jacksonville.	1st Tuesday	8:15 P.M.	Mayflower Hotel Jacksonville	No.	60%
Escambia	J. M. Hoffman, M.D., Pensacola.	2nd Tuesday	8:00 P.M.	Board of Health Building Pensacola	No.	31%
Hillsboro	John S. Helms, Jr., M.D., Tampa.	1st Tuesday	8:00 P.M.	Tampa Municipal Hospital Tampa	No.	90%
Jackson	Lewis Pierce, M.D., Marianna.	2nd Tuesday	7:30 P.M.	Hotel Chipola, Marianna	Yes.	77%
Lake	W. L. Ashton, M.D., Umatilla.	1st Thursday	12:30 P.M.	Eustis	Yes.	79%
Lee	H. Quillian Jones, M.D., Ft. Myers.	3rd Friday	7:30 P.M.	Lee Memorial Hospital Ft. Myers	No.	90%
Leon-Gadsden-Liberty-Wakulla-Jefferson	O. G. Kendrick, M.D., Tallahassee.	Quarterly	8:00 P.M.	Varies	Yes.	77%
Madison	Geo. O. Davis, M.D., Madison.					100%
Manatee	W. D. Sugg, M.D., Bradenton.	3rd Tuesday	7:00 P.M.	Whitfield Country Club Bradenton	Yes.	75%
Marion	Richard C. Cumming, M.D., Ocala.	3rd Thursday	12:30 P.M.	Marion Hotel Ocala	Yes.	100%
Monroe	W. R. Warren, M.D., Key West.	1st Sunday	9:00 P.M.	Varies	Yes.	
Orange	John A. Pines, M.D., Orlando.	3rd Wednesday	8:30 P.M.	Varies	No.	96%
Palm Beach	Lloyd J. Netto, M.D., W. Palm Beach.	4th Monday	8:00 P.M.	Good Samaritan Hospital W. Palm Beach	No.	100%
Pasco-Hernando-Citrus	John J. Bourke, M.D., Dade City.	2nd Thursday	7:00 P.M.	Varies	Yes.	77%
Pinellas	O. O. Feaster, M.D., St. Petersburg	1st Friday	8:00 P.M.	Assembly Room, 5th floor, P. & L. Bldg. St. Petersburg	No.	90%
Polk	J. R. Boulware, Jr., M.D., Lakeland.	2nd Wednesday in Feb., Apr., June, Aug., Oct., Dec.	1:00 P.M.	Lakeland	Yes.	91%
Putnam	E. W. Warren, M.D., Palatka.	2nd Thursday	7:00 P.M.	James Hotel, Palatka	Yes.	57%
St. Johns	John L. Bennett, M.D., St. Augustine.	3rd Tuesday	8:30 P.M.	Varies	Yes.	100%
St. Lucie-Okeechobee-Indian River-Martin	J. D. Parker, M.D., Stuart.	3rd Thursday	8:00 P.M.	Varies	Yes.	
Sarasota	J. E. Harris, M.D., Sarasota.	2nd Tuesday	8:30 P.M.	Varies	Occasionally.	93%
Seminole	J. T. Denton, M.D., Sanford.	2nd Monday	7:00 P.M.	City Hospital Sanford	Yes.	100%
Sumter	W. E. Mitchell, M.D., Coleman.	2nd Tuesday		Varies	No.	100%
Taylor	C. A. O'Quinn, M.D., Perry.	Last Friday	8:00 P.M.	Dixie-Taylor Hotel Perry	Yes.	100%
Volusia	Hugh West, M. D., DeLand	2nd Tuesday	7:30 P.M.	Varies	Yes.	74%
Walton-Okaloosa	A. G. Williams, M.D., Lakewood.	3rd Thursday	8:00 P.M.	Varies	Occasionally.	100%

NOTE—Secretaries: Please submit information to complete the above schedule.



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THE JOURNAL
— OF THE —
Florida Medical Association, Inc.

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NO. 11

Jacksonville, Florida, May 1935

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NEXT SESSIONS Florida Medical Association, S.S. Florida.
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Southern Medical Association, St. Louis, November 19-22, 1935

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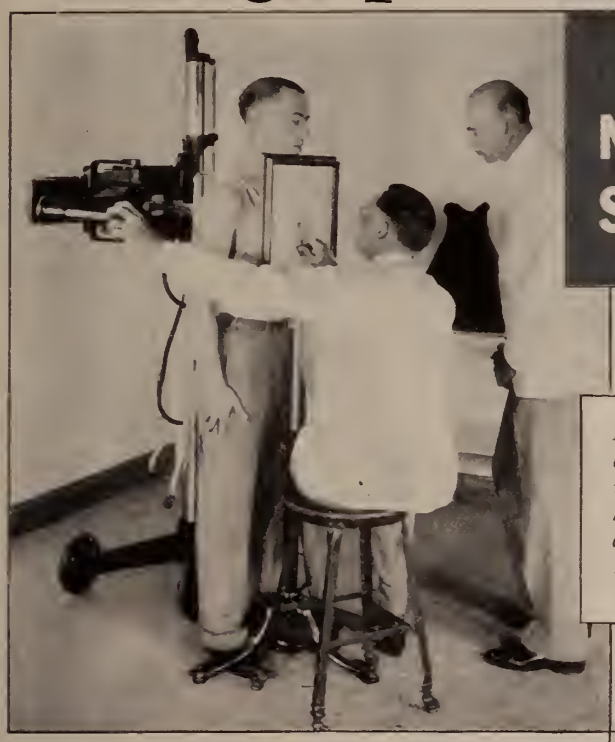
This does not mean, of course, that all special diets are harmful. Frequently, a proper diagnosis reveals that a carefully planned diet is just what is needed. But a proper diagnosis can be made *only* by your doctor . . . and the proper diet can be determined only by your doctor.

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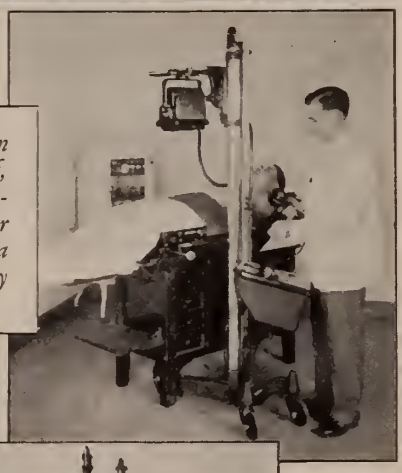
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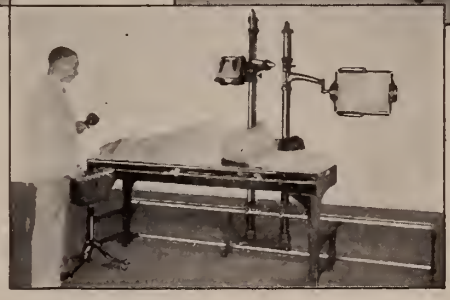
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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
PUBLISHED MONTHLY

Volume XXI | Jacksonville, Florida, May, 1935 | Number 11

The Physician and His Government*

Homer L. Pearson, M.D.,
Miami.

In attempting to discuss a subject of this nature in the shortest possible time it will be necessary for me to touch the high places only and therefore some of my remarks might seem drastic; for that reason I wish to have it clearly understood at the beginning that what I say are my own personal views and that while I am trying to convince this Association that I am right, it might be well for any who might wish to quote from this talk to say: "This is the view of the retiring president."

A great many things have come to my attention since I have been in your service about which I would like to talk, but time does not permit me to discuss all these matters now; therefore, I shall limit my remarks to those items that are of a political nature and their relation to the Medical Association.

As a matter of review, I would like to remind you that at our Jacksonville meeting of the House of Delegates one year ago, we passed a resolution addressed to the Board of Commissioners of State Institutions requesting a number of changes to be made at the State Hospital in Chattahoochee, chief among which was the appointment of a trained psychiatrist as superintendent of the institution. All the pressure the Association possessed was brought to bear, but to no avail. In a very few words it is possible for me to tell you why we were unable to secure this appointment. It was and is simply because we do not speak the language of the politician. We do not speak in terms of votes, and "votes" is the big word in the vocabulary of the politician.

For the past few years there has been a drastic effort put forth by the counties of southeast Florida to rid them of mosquitoes. At the beginning of this work it remained surprisingly clear of politics but as it became known to them that there was considerable money spent in this project and that it was handled almost entirely by scientific men, the politicians began to try to gain control by appointing a man of their choice to head the mosquito control work. This was done in spite of contrary recommendations made by the scientific men then sponsoring the project. Their appointee was without previous training but was a good politician. The man recommended by those most interested was ignored, yet he had excellent training and experience in mosquito control. We would have lost control of this project had the State Board of Health not refused to accept the appointee of the politicians. We at last were able to have the proper man placed in control. It was not, however, because of any influence we had, for we cannot speak authoritatively in terms of votes.

For many years the Florida Medical Association has had legislative programs. We have expended money and energy, yet we have been almost completely ignored in our efforts to put over legislation. Always the cry came back that we were not willing to spend enough money. It has always been my opinion and the opinion of some others of this Association that legislation that we must buy is better not had. This year is the first in which we have been able to accomplish much. We have enjoyed some success because of two things: first, we have had at the head of our legislative committee a man who understands politicians and can speak their language. It has been said that anyone growing up in West Florida must be a politician by the time he reaches his majority, or must move. The Chairman of our Legislative Committee lives in West Florida and is over 21 years of age. The second reason for our success is because we have, under his guidance, carried out a definitely outlined program of approaching our Legislators

*Presidential Address, delivered before the Sixty-second Annual Meeting of the Florida Medical Association, held in Ocala, May 13, 14, and 15, 1935.

before they went to Tallahassee and in a small way, playing politics. I wish to state now that if this administration has been unsuccessful in every phase of organized medical endeavor, it exercised rare judgment in selecting Julius C. Davis to head the Legislative Committee.

I cite you the above experiences to show that by following the course we have followed for many years past, we will get nowhere.

When laws for the compensation of workmen injured in industrial life were being enacted the medical profession was conspicuously absent. Representatives of employers, of labor unions, and of insurance carriers, as well as social workers, were always present and took marked interest in framing these laws. Their interests were decidedly selfish—in the case of most of them, entirely financial. The right quality of medical care for the injured man, when and where he would secure it, and his restoration to perfect health, which was the main interest of the law, were, in the absence of the authoritative voice of the profession, barely discussed, or were relegated to some subordinate position. It is not surprising, then, that in the constitution of boards to administer the law dealing with injured people, physicians were not represented. It is only now, after many years of administration, that the important place of the physician is being recognized and a realization reached that the many mistakes and failures of these years could have been averted if his special knowledge and experience had been adequately used.

We have seen even more recent efforts on the part of the laity to draw up legislation governing the practice of medicine without granting us the common courtesy of saying whether we like it or not. I have reference to the now well-known "National Social Security Act" and to the more recent "Social Welfare Act of Florida."

Some weeks ago I received a letter stating that the Governor had appointed a "Commission on Social Legislation," the duties of said commission being to draw up suitable legislation for State Social Security. I became a little suspicious that this group had some connection with the national group since not one doctor was placed on the commission to formulate legislation for social welfare—and so expressed myself, and about two weeks ago I received another letter from the Chairman of the Commission which reads in part as follows:

"We understand that members of the medical profession have confused the welfare legislation, known as 'The 1935 Social Welfare Act', with some of the national measures which include health insurance.

"This is understandable since the bill was originally introduced under the title of the 'Florida Social Security Act' but has since been changed as above. The legislation which we are supporting contains only one reference of special interest to the medical profession which is as follows:

"'Medical care and attention for those who may be subject to the jurisdiction of the State Board or District Boards may be provided in hospitals, dispensaries, the person's home, or any suitable place, as provided for and directed by said State or District Board'."

The creation of the State Board of Social Welfare, as proposed by the Commission is as follows:

"The administration of social welfare in the State of Florida shall be vested in the State Board of Social Welfare which shall consist of seven members, three or more of whom shall be women, and who shall be appointed by the Governor."

I never have and never will consent for a board of laymen or laywomen, if you please, to direct my medical practice—and in this proposed law they come out flat-footed and say that "medical care and attention for those who may be subject to the jurisdiction of the State Board are provided for and directed by the State Board."

Gentlemen, the time has come when we must do something about it. It is my plan to state briefly what I think can be done:

In the strenuous performance of his many duties, the average physician has not had the time nor the inclination to take an active part in the affairs of government, though it would be to his interest to do so—yet, even a brief discussion of the wide influence of the physician, dare not wholly neglect the relation of the physician to standards of conduct and to regulation of behavior. Upon the physician, by virtue of his special opportunities, there falls an unusual obligation to perform a public duty with regard to ethical standards and the rational control of human action. Medical students become acquainted with the principles underlying different forms of animal and human behavior. Physicians, in their manifold contacts with people, have a better chance than most men to learn how the behavior of persons is regulated, how rights are maintained and how duties are enforced. They soon find out, too, the rules for determin-

ing what the rights and duties are in the main relations of life. The sympathetic relationships with individuals, families, and other social groups entered into by physicians, the esteem in which doctors are generally held in the communities in which they live, as well as the social prestige that they enjoy, enable them to exert, at times, an important influence upon the formation of conduct standards and upon the agencies for promoting behavior that is in accord with social welfare.

I would like to quote briefly from an article by Senator Royal S. Copeland in "Medical Economics" of recent date: "The social breakdown of the present time is one that the physician can understand better than perhaps anyone else. Even in normal times he came constantly into contact with the problems of poverty and dealt with it as effectively as anyone could. Surely the public at large has had little cause for complaint about what the doctors have done for them. Indeed, the physicians of this country have set an example of civic decency, which, in my judgment stands unparalleled.

"Now that we have poverty on a nation-wide scale, there comes, as never before, a call to the medical profession to enter the field of politics. Never before has there been such a real need for medical men in politics. England rules the seas because her shipping interests have always seen to it that there are in Parliament strong men connected with the merchant marine, alert to forestall any legislation harmful to shipping interests. This, it seems to me, may well be an example to the medical profession of the United States.

"Able physicians must be willing to sacrifice their private practices, even, temporarily, and serve in legislative bodies. I am confident that their very presence there would be a guarantee not only of a better deal for the medical profession, but for the public at large."

We must have medical men in the legislative halls who have the intestinal fortitude to fight for what they know to be right and this Medical Association must have leaders and statesmen who are able to and willing to lead us out of the wilderness of confusion.

It is not only necessary that we have representatives in legislative halls but equally important that we have a profession undivided in their aims and efforts, and loyal and united in their support to those who are loyal to us, and who are in accord with us in our efforts to keep our profession free from unholy tyrannies and alliances.

It does not seem likely that the medical profession will again neglect to take its proper stand on all those social questions which affect the people of this country nor fail to contribute its thought to the solution of the problems. Aggregations of wealth, social workers, and professional uplifters have shown us in the past few years how eagerly they seek the control and regulation of matters with which the doctor is most intimate and from which, in their plans, he would be almost completely excluded.

Let me remind you that the medical profession of this state consists not only of medical doctors, but of dentists, pharmacists, and nurses, who are willing and anxious to join forces with us. We, with our combined forces and influence, can wield an influence that is second to none.

The members of the medical profession of our sister state of Alabama have, after thirty years of concentrated, united effort, obtained control of the medical legislation of their state. In fact, they are the medical legislature of their state. Their medical laws are drafted and passed by the Alabama Medical Association. Such should be the case in Florida. We should control the State Board of Health, the State Board of Medical Examiners, the state, county and city hospitals, the dispensing of medical care to the indigent of our state, and, in fact, every phase of endeavor which has to do with the medical aspects of people. Whether you like politics or not, it is your civic and professional duty to take an active part in this great work. We must see that the proper safeguards are thrown about our people, and our profession, by formulating the correct and proper laws, and, above all, to obey those laws and see that others do. Don't "pass the buck." Do your share as good citizens should. To many you are endowed with almost superhuman knowledge. Do not fail them in their hour of need, and, on the other hand, our profession is now passing through "The Valley of the Shadow of Death" and unless we draw our swords and show some fight we are soon going to be as servants to the politicians, rather than to our rightful masters, the sick and afflicted people of our state.

Remember that it is not becoming for the medical profession to beg crumbs from the political master's table.

PROCEEDINGS

of the

SIXTY-SECOND ANNUAL MEETING

of the

FLORIDA MEDICAL ASSOCIATION, Inc.

HELD AT OCALA, FLORIDA

MAY 13th, 14th, and 15th, 1935

The Sixty-second Annual Meeting of the Florida Medical Association was called to order at 4:00 p. m. Monday, May 13th, in the Dixie Theatre, Ocala, Florida, by Dr. Eugene G. Peek, Chairman of the local Convention Committee.

The Invocation was rendered by The Reverend John A. McMurray, pastor, First Presbyterian Church, Ocala.

The Honorable B. C. Webb, Mayor of Ocala, gave the address of welcome.

The names of the delegates from the Georgia Medical Association were read but the delegates were not present.

Dr. Homer L. Pearson, President of the Association, in the Chair.

The President then introduced Don S. Evans of Orlando, representing the Florida Pharmaceutical Association. Dr. Evans:

"I wish to express my sincere thanks to the President of your organization for this kind invitation, and I assure you it is a real pleasure to be here. I feel by this invitation that President Pearson has made a very sincere gesture toward cooperation between our closely related professions. I appreciate it more than words can express. Also, if I may add, this friendly relationship between the Physicians and the Pharmacists is bound to be of mutual benefit to both of our interests.

"In Florida we have Pharmacy which is as high in standard and with requirements as rigid as in any State in the Union. In order to become a Pharmacist in Florida the applicant must be a high school graduate, he must have completed four years in the study of pharmacy, and have had one year of practical experience before he can take the State Board Examination and become eligible to apply for a license. These rigid requirements in Florida result in benefit to the Physician and his patient alike.

"We now have at the University at Gainesville a school of pharmacy which is second to none and they are turning out graduates of the highest type.

"We feel also that in Florida we have as fine, as fully equipped, and as thoroughly trained, physicians as there are in the nation. We have the greatest admiration and respect for the Florida Medical Association and its members, and we want to cooperate with you in any project for the advancement of the public health of Florida or the improvement of our respective professions.

"There is just one thing that I would like to bring before you—it will only take a few minutes—and that is the legislative program at Tallahassee.

"We have introduced two bills in the Legislature which I think might be of interest to you. One puts the sale of contraceptives and prophylactic goods under the supervision of the State Board of Health. They can only be dispensed by stores registering with the State Board of Health. This measure was introduced to insure that the quality of the merchandise would be such that it would really prevent disease, which is not the case now.

"The other bill is to restrict the sale of drugs and medicines to stores which employ registered pharmacists.

"We have insufficient time to expound the merits of these two bills. Both have passed the Senate and we feel that there is an excellent chance of getting them through the House. However, if it is agreeable with you I would like to leave copies of these bills with your Secretary and have them referred to your Resolutions Committee or other suitable committee if you care to take any action on them. A copy of your resolutions to us and to your Legislators would be a help.

"I would like to add, also, that if there is any

of your legislation in which we could be of assistance we ask that you call on us because we have good contact with the Legislature and we might be able to help you.

"In closing, let me say it is our desire to work in harmony with you, to promote further friendly relationship and cooperation to our mutual interest.

"Again I thank you for your sincere invitation."

C. P. Cleveland, D.D.S., representing the Florida State Dental Society, was then introduced by Dr. Pearson and read the following address:

"Mr. President, Members of the Florida Medical Association, and Guests: In behalf of the Florida State Dental Society, which I am honored to represent, I am happy to greet you. It is a pleasure to reciprocate the courtesy paid our society by Doctor Pearson last October when he addressed our convention in Pensacola.

"I am happy to be able to say that in recent years the bonds of mutual understanding and respect and interdependence have grown stronger between our two professions.

"Not many years ago doctors of medicine too frequently considered diseases of the mouth as a distinct entity and too often overlooked their relationship to ailments in other parts of the body. Now, needless to say, this has been changed. Modern medicine now looks to modern dentistry for the proper diagnosis and treatment of dental ills. It therefore behooves us dentists to keep abreast of modern scientific developments that we may retain the trust placed in us by you physicians.

"Unfortunately, dental research is not well endowed, and much of that which we have is not properly coordinated. The American Dental Association yearly appropriates small grants to certain individuals, groups and institutions to further dental research. To their credit, let it be said that much valuable information has been obtained in this way.

"The United States Bureau of Standards has also cooperated in testing and standardizing dental materials, but has not, I believe, entered the field of research.

"Most fruitful has been the research done in the dental colleges of our universities. In recent years many of these schools have come to realize their responsibility, not only of turning out competent dental surgeons, but also of increasing the sum of dental knowledge.

"Outside the field of research there exists another body which is currently making valuable contributions to dentistry. I refer to the Council on Dental Therapeutics of the American Dental Association. This council is engaged in examining the various drugs and preparations, both proprietary and non-proprietary, together with their advertised claims. Those that are found rational in composition, beneficial in use and honestly advertised are accepted by the council and are privileged to use the seal of acceptance of the association.

"Now to get closer home, I should like to tell you something of the aims and accomplishments of my own group, the Florida State Dental Society. We list as members about two-thirds of the white practicing dentists in the State. The membership numbers slightly less than four hundred. Our percentage of membership is well toward the top as compared to other states.

"We have always exercised a jealous watch over our state board of dental examiners, and thanks to this fact and to a most cordial relationship between the society and the various state administrations in Tallahassee, the personnel and the transactions of the board have been kept on a high plane.

"Due to Florida's peculiar climatic and geographic situation, our society has been in the past and still remains opposed to reciprocity of license with other states.

"Our constant endeavor has been to assist the board in keeping the highest possible legal requirements for license in Florida. It may interest you to know that at the present time our society has introduced in the legislature, an amendment to the dental law, which will permit the revocation of license of any dentist who advertises.

"We expect to stamp out this practice of fraudulent dental advertising, so long employed by these quacks and charlatans to fleece the more gullible portion of the public.

"The state of Oregon, in 1933, made dental advertising illegal. Subsequent litigation has been carried through the Oregon Supreme Court and the United States Supreme Court. Each of these courts upheld the law by unanimous decisions.

"Our society is most hopeful for the enactment of this pending legislation in our own state and

commends similar measures to your association to curb medical advertising.

"Within the past two years your profession and mine have been bombarded from without and heckled from within by an element who would seek to change and regiment medical and dental practice and put it under control of the state.

"Because thousands have always been and are still without adequate health service the finger of shame is pointed at medicine and dentistry. Gentlemen: my profession and yours have no apologies to make. Certainly none are due, for physicians and dentists have always given freely of their only assets; knowledge and time, to the deserving poor. What other groups can say as much?

"We are told that in comparison to Europe, America is twenty-five years behind the times in the various measures for social security. Such statements remind me of the story of the little girl who refused to eat her spinach. Her mother took her to task and said, 'Mary, there are hundreds of little girls who would be glad to eat your spinach.' 'Alright,' said Mary, 'Just name one.'

"I would ask these self-appointed critics of our American social system to 'name one' nation in Europe where a living is so secure, and where the average citizen enjoys so many advantages and so much freedom, and so great a measure of social security as here in the United States of America.

"If our people do accept the policy that health service to the individual is a function of the government, let them bear in mind that such service is essentially personal, and cannot be furnished by methods of mass production or chain store distribution. Let them bear in mind that the quality and quantity of individual effort will largely be governed by the remuneration received, and that because of this fact good medical and good dental service can never be cheap."

Dr. Pearson: "I want to thank you both for being kind enough to speak to us at this time. I think you should know we appreciate the fact that with a closer union between our respective associations we can accomplish a great deal both professionally and politically. Doctor, I wish you a most successful convention in Jacksonville. I thank you both for coming."

The following report of the Committee on Legislation and Public Policy was read by Dr. J. C. Davis, Chairman:

REPORT OF THE COMMITTEE ON LEGISLATION AND PUBLIC POLICY

Your Committee has had a very hectic year. I believe that the ice has been broken and that pressure has been brought to bear, as never before, relative to the recognition our profession is entitled to at the hands of our Legislators. An enlightened public sentiment is the greatest weapon one can wield against a public nuisance, and enlightened legislation only will protect the public and our profession against the invasion of quacks, preying upon the hosts of the unfortunately less informed. Careful study of the existing Medical Practice Act, one we thought an excellent one, showed that it would be necessary to make some changes in order to fully enforce the intention of this Act. Therefore it was necessary to introduce several amendments, drafting a new Bill for each one. They are as follows:

1. Senate Bill 147—A thorough definition of the practice of medicine and provision for the proper designation for the different members of the healing arts.

2. Senate Bill 144—Provisions for the legal enforcement of this Act, in no uncertain terms.

3. Senate Bill 141—Definition of the word physician in the Florida Code.

4. Senate Bill 145—Amendment of the Narcotic Act, in order that there will be no question as to who shall be the recipient of a Narcotic license.

5. Senate Bill 146—Requirement of United States citizenship before being permitted to take the medical examination, before the Board of Medical Examiners.

6. Senate Committee Substitute Bill 142—requirements for registration and re-registration for practicing the healing arts.

7. House Bill 145—A Lien Law, endeavoring to aid hospitals and physicians to collect from those responsible for an injury.

Realizing that the above would be a gigantic task, an attorney was employed to draft these Bills and submit them to Dr. R. C. Woodward, Director of the Bureau of Legal Medicine and Legislation, of the American Medical Association, for suggestions and criticisms. These Bills were submitted at the Pre-Convention meeting in Orlando, with unanimous consent and approval by the members of your Committee on Legislation and Public Policy, the Executive Committee and the Board of Councilors.

On February 8th, a letter was mailed, by the Chairman of your Committee to every member of the Senate and House of Representatives, informing them that we proposed to introduce certain bills which would prove of vital importance to the public and our profession. We insisted that they meet with the Legislative Committee, appointed from the members of their own County Medical Society, carefully consider these bills and let us have a definite answer as to whether they proposed supporting them or not. It was realized that all worthwhile legislation is made at home and not at Tallahassee. This was proven as the members of the Senate voted favorably on these bills, with one exception and then only by two dissenting votes, and these members voting nay, I do not believe, were ever consulted by their physicians at home. The majority of the Senators and quite a few of the Representatives answered very promptly, replying that they would be delighted to meet with their home physicians and that their support of these measures would be largely determined by the advice received from these gentlemen, whom they held in such high esteem. A copy of these letters, with the proposed bills, were then mailed to the contact men, about February 15th, and the most difficult task was to get these physicians to confer with their Legislators. They were all apparently willing, but inclined to procrastinate, and it was necessary to write and re-write them before getting any action.

Probably our most important work has been accomplished in defeating adverse legislation, namely:

House Bill 91—Proposes to repeal the existing naturopathic practice act and to enact a new naturopathic practice act. The bill proposes, in effect, to extend greatly the scope of a license to practice naturopathy. It purports to permit licensed naturopaths, in addition to the practice now permitted, to practice physiotherapy, electrocoagulation and electro-therapy. It also removes the express provision in the existing law prohibiting naturopaths from practicing Materia Medica or surgery.

House Bill 748—An Act providing for licensed practitioners of all schools of the healing art to enter all hospitals or institutions maintained in whole or part by public funds in this State and treat their patients therein, and repealing all laws in conflict herewith.

House Bill 816—An Act empowering and authorizing all persons licensed by the several boards of this State to practice the Healing Art, to make examinations and issue certificates showing the condition of all persons required by any of the laws of this State to be examined for any purpose whatsoever.

These were unanimously defeated by the Committee. On account of this House Bill No. 831 has been introduced: "H. 831 proposes to repeal the existing naturopathic practice and to enact a new law creating a board of naturopathic examiners and regulating the practice of naturopathy. The bill proposes to define naturopathy as "the use of and practice of physiological, mechanical and material health sciences to aid in purifying, cleansing and normalizing human tissue for the preservation or restoration of health according to the fundamental principles of anatomy, physiology, and applied psychology as may be required. Naturopathic practice employs among other agencies, phytotherapy, dietetics, phychotherapy, suggestotherapy, hydrotherapy, zonetherapy, biochemistry, external applications, electrotherapy, mechanotherapy, heliotherapy, mechanical and electrical appliances, hygiene, first-aid, and sanitation." You will observe that Materia Medica is left to them. I am assured that this bill will meet the same fate as the others mentioned. It would have been impossible to have kept up with the Public Health Committee meetings and copies of these bills, had it not been for the excellent work of our attorneys, Gregory and Towles, and the aid from the Legislative Bureau, operated by Mrs. Bostwick. I feel that we have learned from experience a lesson of untold value. If we expect to protect the public and our profession we must eliminate petty politics in our cities and counties. We must be absolutely united with the standing Legislative Committee from each county and district. Each time an aspirant to the Legislature makes his announcement as a candidate, he must be immediately contacted and asked to commit himself as to whether he will support organized medicine and be guided by his County Medical Society in casting his vote on measures affecting public health and medicine. In this way and in no other will we be able to have Legislation enacted that we desire.

At the end of the present session of the Legislature I propose to inform each Medical Society just how its members voted on each and every medical bill.

You men can do a great deal of good by studying your proposed Legislation beforehand and help your State Committee by sending in your criticisms early. Many criticisms and suggestions were mailed to me after the bills had been introduced. Several members of the House have told me that they had not been contacted by their medical men at home, wondering why—just a case of putting it off on the part of our own profession.

During the year many questions have arisen that necessitated careful thought and consideration. The American Association of Social Security of New York asked me to support their bill. I quote my reply, which was given to the press: "After reviewing carefully the tentative draft of a model State health insurance bill it is our reaction that this bill is un-American and a direct insult to organized medicine and all of its past achievements. It is in violation of the principles upon which this government was founded —freedom and independence. It will incur at the taxpayers' expense a great racket and provide luxurious payrolls in creating many unnecessary commissions for people totally ignorant of the needs of the people. It will destroy the personal equation between patient and physician. It will take from the employe and employer alike that which will be needed for legitimate physicians and their patients. In other words the poor will grow poorer and the racketeer wax fatter.

"There is no country to which you might refer us that socialized medicine has been satisfactory to all classes. It is apparent that such is the beginning of the fall of a great empire, also the death knell of organized medicine. The Florida Medical Association proposes to fight the enactment of any such unfair and one-sided legislation."

The State Social Welfare Committee requested that we support their House Bills Nos. 517 and 518. Here is my answer to Mrs. Fuller: "I am glad that your Bill No. 518 was introduced as a Social Welfare Act rather than a Social Security Act, as the words Social Security are very repulsive to the medical profession. Your bill seems to have many good features, most of which are no doubt necessitated by the fact that county officials are not using the authority vested in them to deal with such situations. At the same time it appears that there is always someone sponsoring dictatorial and paternalistic ideas at the expense of the already over-burdened taxpayers. County Commissioners should be forced to take care of the main issues in this Bill.

"Your House Bill No. 517, in my mind, is another burden on the taxpayers, as our County and Circuit Court Judges are idle fifty per cent of their time, and they could certainly act as Juvenile Court Judges, without an additional fee. In fact I believe that your Bill, or a similar bill, drafted, adding this additional responsibility, with no increase in salary, would solve your problem. Insofar as I can see your Bills do not antagonize organized medicine and you know we are unalterably opposed to any centralization of medical practice. Neither do we propose to be dictated to from outside mercenary corporations, sailing under the banner of Social Security, or whatnot."

In the future may I suggest for your approval that each County Medical Society have one Auxiliary member of the Legislative Committee who will work with the three active members; also that closer contact with Pharmaceutical and Dental Associations be encouraged, and work in harmony with their Legislative Committees. Last, but not least, a fund should be set aside for combatting harmful legislation.

I am opposed to the Association entering into controversies over political positions, when our Association is not directly benefited, and most often to our detriment. With the proper tact the Administration will generally support us. Then support the Administration and let all political controversies be handled through an Arbitration Committee.

Respectfully submitted,

J. C. Davis, M.D., Chairman;
S. E. Driskell, M.D.,
C. E. Tumlin, M.D.

Dr. Pearson: "This is a thankless job, and Dr. Davis has handled it well. In all due respect to the Florida Medical Association, I don't know of any man who could have handled the chairmanship of the Legislative Committee this year as well as Dr. J. C. Davis has. And I want to thank him personally for his work."

It was moved, seconded and unanimously carried that Dr. Davis' report be adopted.

The report of the Committee on Hospital and Medical Education was read by Dr. H. F. Watt, Chairman, as follows:

REPORT OF THE HOSPITAL AND MEDICAL EDUCATION COMMITTEE

Your committee has been handicapped this year on account of the resignation of Dr. Woodard as chairman. Your present chairman has held office a little over a month, and it has seemed impossible in this short length of time to accomplish any real constructive work. We have secured from the American College of Surgeons a list of hospitals in Florida surveyed this year and the tentative ratings indicated, and this list is attached to this report, but this is not for publication as some of these may change their ratings after a follow-up is completed. The official list for 1935 will be published on October twenty-eighth this year.

A study of this tentative list reveals out of a total of forty-five hospitals inspected, twenty-seven are fully approved, three provisionally approved and fifteen are not approved. In other words one-third are not approved.

Comparing this report with previous years shows several changes; some have gained full approval and others that were fully approved are now only conditionally approved. According to the American College of Surgeons there are three main causes keeping so many hospitals off the approved list in Florida. These are:

1. Lack of proper medical staff organization.
2. Poor quality of medical records.
3. Lack of competent medical supervision over the clinical laboratory and x-ray department.

The House of Delegates of the Florida Medical Association in 1929 voted to adopt a set of "minimum requirements" for the standardization of all hospitals in the state. This was undoubtedly a valuable idea, but it has been impossible to contact the hospitals of this state and determine in what degree they are complying with these rules.

Another matter that occurs to us is that there is a duplication of effort on the part of the American Medical Association, the College of Surgeons, and the Florida Medical Association in the matter of hospital inspection and regulation. If these various efforts could be coordinated it would result in greater efficiency.

It is the recommendation of your committee that the incoming committee on Medical Education and Hospitals be instructed to contact a similar committee from the Florida Hospital Association and work out a joint program for the betterment of the hospitals of the state. In this way we feel that the greatest good will result. A similar recommendation was made by your committee in 1933. Your committee feels that with the cooperation of the Florida Hospital Association it may be possible to stimulate a greater interest in hospital standardization.

Respectfully submitted,

THE MEDICAL EDUCATION AND HOSPITAL COMMITTEE.

HARRY F. WATT, EUGENE B. MAXWELL.
HAYNES BRINSON,

Dr. Christ: "I want to talk about hospitals. The whole value of the American Hospital Association, the American Medical Association and the American College of Surgeons seems to be in working out an audit proposition, but the State of Florida should designate the kind and type of institutions which are to be called hospitals."

It was moved, seconded and carried that the Hospital Committee's report be adopted.

The following report of the Committee on Necrology was read by Dr. Henry E. Palmer, Chairman:

REPORT OF COMMITTEE ON NECROLOGY

During the past year, our Association lost, by death, the members whose names are listed below:

Frederick Greene Barfield, Jacksonville
C. W. D'Alemberte, Pensacola.
Gaston Holcombe Edwards, Orlando
James Martin Joshua Luke, Miami
Albert S. Munson, DeLand
Harry L. Putnam, St. Petersburg
Horace Lee Simpson, Pensacola
Cyrus J. Strong, Miami
L. R. Weeks, Trenton
Julius T. Westermann, Miami

Where possible, obituaries have appeared in the Journal relative to the deaths of these doctors. Tributes have been paid to them in the different communities where they practiced.

May we, at this time, stand in a moment of silence, in reverence and respect to the memory of our departed colleagues.

HENRY E. PALMER, Chairman:
FERDINAND RICHARDS,
ISAAC M. HAY,
WILLIAM G. POST, JR.,
JOHN D. MILTON,
DAVID R. KENNEDY.
CHARLES J. COLLINS,
HARRY C. GALEY.

Dr. Pearson: "A convention of the Florida Medical Association seems incomplete without the familiar faces of some of these men whose names have just been read. There has not been a greater supporter of organized medicine than Gaston Edwards. I have never attended a Medical Association meeting in Florida at which Gaston Edwards was not present and taking an active part. In 1931 he was President of this Association, and he presented us with the gavel that we are now using. We have devoted memories of Gaston Edwards."

On motion duly seconded the above report was unanimously adopted.

Dr. J. Ralston Wells, Chairman, read the report of the Committee on Public Relations, as follows:

REPORT OF COMMITTEE ON PUBLIC RELATIONS

A summary of the work accomplished by this committee, is as follows:

Several meetings were held during the year.

The Speakers' Bureau was formed, with most of the County Societies sending in the names of speakers nominated by the society. So far Leon, Pasco, Lee, Taylor, Pinellas, Marion, Alachua, Lake, Orange, Columbia, Escambia, Volusia, Polk, and Broward Counties have sent in their names.

The Public Relations Committee again this year put on a broadcast program over station WRUF in Gainesville. There was a paper presented each week over this station for twenty-one weeks. The speakers, for the most part, kept their appointments. The papers of the speakers who were unavoidably detained were read over the radio, through the courtesy of Major Garland Powell, his staff at the station, and Dr. G. C. Tillman. At the last meeting of this Committee, a motion was made and carried that the names of the doctors reading papers over the radio should be announced.

The Public Relations Committee drew up a petition to the A.M.A. requesting a series of broadcasts over a national broadcasting chain, depicting and contrasting medical care at the present time with medical care received in the nineteenth century, and later. This petition was turned over to the executive committee. The executive committee, who approved it, instructed the delegates to the A.M.A. to present this petition at the special session of the house of delegates of the A.M.A.

Director Garland Powell (WRUF) has invited us to broadcast once a week throughout the year. The committee will be glad to accept this generous offer, providing it can effect an adequate support in regards to members of the society volunteering their services, and in so far as is possible, keeping their appointments at the radio station.

Respectfully submitted,
J. Ralston Wells, Chairman;
J. Rocher Chappell, Secretary;
Hubert A. Barge,
Thomas E. Buckman,
Henry C. Dozier,
H. Mason Smith.

Dr. Pearson: "Dr. Wells has had difficulty in securing twenty-one speakers to carry on the broadcasting program. It is necessary that we know definitely of a sufficient number of men who will be willing to go to Gainesville and broadcast before we can give a satisfactory report to the Broadcasting Staff at Gainesville. I think it advisable at this time that all of you men who will cooperate with Dr. Wells in carrying on this broadcasting program to the extent that you will go to Gainesville and make a talk when you are invited to go, hold up your hand so that Dr. Wells can tell who you are:

The following doctors gave their promise as individuals:

C. D. Christ,
H. C. Dozier,
Henry Hanson.

Pledges of County Medical Societies:

Polk County: Requisite number pledged by Dr. Cline.
Hillsboro County: Three.
Pinellas County: One.
Pasco-Hernando-Citrus County: One.
Columbia County: Two.
Brevard County: Two.
Orange County: Two.
Lake County: Two.
Palm Beach County: Three.
Escambia County: Two.
Duval County: Three.
Dade County: Five.

It was moved, seconded and unanimously carried that the above report be adopted.

Motion by Dr. Wells that the Association wire Major Powell at Station WRUF, thanking him for his courtesy and cooperation with the Florida Medical Association during the past year.

Seconded and carried. So ordered.

Dr. Gerry R. Holden, Chairman, read the following report of the Committee on Cancer Control, which was adopted:

CANCER CONTROL COMMITTEE REPORT

During the past year this Committee adopted a plan which was used satisfactorily the previous year. The state was divided into districts. One member of the Committee was assigned to each district and assumed responsibility for carrying out the work in that district.

Dr. Dickinson took charge of the following counties: Citrus, Hernando, Pasco, Sumter, Hillsborough, Pinellas, Polk, Manatee, Hardee, Sarasota, DeSoto, Highlands, Charlotte, Glades, Lee, Hendry.

Dr. Hoffman took charge of Escambia, Santa Rosa, Okaloosa, Walton, Holmes, Washington, Bay, Jackson, Calhoun, and Gulf.

Dr. Raap took charge of Martin, Palm Beach, Broward, Dade, Monroe, and Collier.

Dr. Wells took charge of Volusia, Lake, Seminole, Orange, Brevard, Osceola, Indian River, St. Lucie, and Okeechobee.

Dr. Holden took charge of Madison, Taylor, Hamilton, Suwannee, LaFayette, Dixie, Columbia, Gilchrist, Levy, Baker, Union, Alachua, Nassau, Duval, Clay, Putnam, Marion, St. Johns, and Flagler.

This seems to be about the only system whereby the work can be satisfactorily handled.

Meetings of the Committee have been held at intervals during the year and attempts made to coordinate the work through the state.

Most of the work this year has been centered on meetings with the laity and medical conferences which would tend to emphasize upon the profession the necessity of recognizing cancer in those early cases in which the symptoms were not pronounced.

Medical symposia have been held before County Societies in the following counties: Citrus, Pasco, Pinellas, Polk, Hernando, Escambia, Walton, Okaloosa, Bay, Holmes, Broward, Palm Beach, Dade, Duval, St. Johns, and Volusia.

There has been a marked increase over last year in the number of meetings held in conjunction with Womens Clubs and kindred organizations. This is undoubtedly due to the interest shown in the subject by the Womans Auxiliary of the State Medical Association and by the activities of the Public Health Committee of the Florida Federation of Womens Clubs. Mrs. Illig, the chairman of the Public Health Committee of the National Federation of Womens Clubs, has urged this program upon each State Federation and Mrs. Wm. Pepper of Gainesville, chairman of the Public Health Committee, of the Florida Federation of Womens Clubs, has also made this one of her objectives during the past year.

Meetings and illustrated talks have been made before Womens Clubs during the year, in the following cities: Tampa, Ormond Beach, South Jacksonville, before the Business and Professional Womans Club of Jacksonville, Archer, Floral City and the Pilot Club of Miami. Meetings have also been discussed for Bartow, St. Petersburg and Lakeland, although they have not yet been held in these three places.

Several public meetings have also been held. Under the auspices of the Cancer Control Committee of the Volusia County Society a series of meetings were held in Daytona, DeLand, and New Smyrna. Public meetings were also held in Marianna, Pensacola, and Miami.

Radio talks have been limited to station WIOD in Miami. A series of eight talks were given over this station last summer.

During the first year of this committee's activities an attempt was made to supply teaching hospitals with enough handbooks on cancer from the nursing standpoint to put one of these books in the hand of every nurse connected with the hospital. These booklets have been supplied to the hospitals as requested this year. Also, lectures on the subject have been given to hospital nurses in Tampa, Miami, Jacksonville, and Daytona.

The Committee as such, has made no attempts towards the formation of diagnostic clinics for indigent patients. However, such clinics have been started in Miami.

During the past year there has been evidence that the public is beginning to take more interest in cancer as a public health problem. This has been shown not only in contacts which have been made by individuals, but also in certain lay organizations. Of especial importance is the organization of the John Gorrie Ice Memorial Foundation. This is a philanthropic organization which has among its objectives aid to the cancer work. The organization has been investigated by the chairman of this committee and, apparently, those in charge of the project are not only

proceeding along strictly ethical lines, but also will be in position to give great help to the cancer control movement when their organization is perfected.

The Committee wishes to acknowledge the great help which the American Society for the Control of Cancer has given during the past year. Conferences with Dr. Cox, the field representative of the Society for the Southeast, have been most valuable. The Society also has supplied your Committee, without cost to us, with films, slides, projectoscopes and literature for the medical and lay meetings.

GERRY R. HOLDEN, Chairman;
JOSHUA C. DICKINSON,
JAMES M. HOFFMAN,
GERARD RAAP,
J. RALSTON WELLS,
NICHOLAS BALTZELL.

The report of the Committee on Medical Economics, Dr. H. C. Dozier, Chairman, was read as follows:

REPORT OF COMMITTEE ON MEDICAL ECONOMICS

Meetings of the Committee on Medical Economics were held in Ocala, October 14 and December 9, 1934, and in Orlando, February 7, 1935. Consideration of the profession's interest, financial and otherwise, in the Emergency Relief Administration's program was the chief item of the first and second meetings.

On December 9, a conference was held with representatives of the FERA, Dr. H. Jackson Davis, here from Washington in an advisory capacity to the FERA, and Miss Mabel Berry, the Director of the Social Service Division of the Florida Emergency Relief Administration. The results of this conference, after having been approved by the FERA Administrator and by the Executive Committee of the Florida Medical Association, were published in detail as "Rules and Regulations Governing Medical Care Provided in the Home to Recipients of Unemployment Relief," along with this Committee's preliminary report in the January, 1935, Journal of the Florida Medical Association, pages 298 to 304, to which your attention is again directed.

It is believed that the financial plan was the most satisfactory possible to obtain with this organization with the funds at their disposal. The Committee insisted that the doctors should be paid fees for the treatment of unemployed in their homes and in their offices on a basis of 50% of the average for each community, it being our contention that this represented approximately the cost of rendering these services; that, the differences between these fees and the customary charges should be considered the profession's patriotic contribution and that such an arrangement should be definitely understood as for the duration of the economic emergency existing in our nation and that it in no way was to be considered as establishing a new fee schedule.

The committee has insisted in all its contacts with the FERA that the traditional patient-physician relationship must at all times be respected—that the patient must always be free to choose his medical attendant; that contract practice of any kind be discouraged; and that such few contracts as seemed necessary, such as examining employees of mattress factories, be arranged for the FERA by the county medical societies and not by the FERA directly with competing physicians.

Provision was made for the appointment of State and County Professional Advisory Committees, whose approval was to govern the selection of eligible physicians, to whom complaints of professional services might be made and whose advice was to be sought in the proper care of the sick for whom the FERA is responsible. It will readily be seen that such an arrangement is definitely beneficial and offers definite protection to all concerned.

The new arrangement provides for more adequate medical care than was formerly the case—now, all office practice for those on unemployment relief is paid for on the 50% basis.

Since the FERA does not assume any responsibility for the care of those classes of patients who were provided for, before the birth of this organization, by city and county governments and private charities, they do not pay for services which we render in the hospitals to unemployed individuals. The medical attention for these patients in hospitals, and other indigents in and out of hospitals, has, for ages past, been accepted by the medical profession as its own obligation and the public generally and political administrations particularly have been willing for such an arrangement to continue. Your committee fails to see why the doctors, representing approximately 1% of the population, should assume the entire burden of medical care for these indigents when the obligation is one that should be borne

by the entire community—the 100% and not just the 1%. We believe the time has arrived when some arrangement should be sought for the assumption of this obligation by the county and city, or other political administrations. A prominent county official, who is an experienced politician, recently made the assertion to one of us that the physicians are the only group of individuals who are not being paid for their services or supplies to the communities and that he believed an effort should be made to correct the unfairness of the present plan and that it was his opinion that it would not be difficult to correct. This committee recommends, therefore, that its successor committee consider and formulate a uniform plan to be used by component county societies in "approaching" city and county administrations in an endeavor to correct the existing situation.

The Committee wishes to reaffirm its protest of last year against the competition of hospitals in the practice of medicine resulting in definite losses to physicians of fees to which they, and they only, are entitled. Further, we again protest the exploitation of physicians by hospitals. It should be remembered that the hospital as a corporation provides room, board, nursing and materials, beyond which it has nothing to dispose of; and that the physicians constituting the medical staff must supply the remaining elements to make the service of a hospital whole and effective. The hospital superintendent has no more right to dictate staff functions than the chief of the medical staff has to dictate the hotel-like functions of the hospital. The staff members are essential partners in the enterprise and are not servants of these institutions. Naturally, the staff and superintendent of a hospital are to be responsible to some type of governing board—unfortunately physicians have not insisted upon proper representation on these boards for the protection of their own interests, with the result that such boards are frequently composed entirely of laymen who aid and abet the superintendent in his attitude of considering the staff physicians as the institution's servants. Until medical staffs demand proper respect for their essential partnership in the institution they may continue to expect hospital superintendents to exploit them; until they insist upon assuming their rightful prerogative of dictating staff policies, they may continue to expect the hospital superintendent to create revenue for his institution by practicing medicine with lay employees in direct competition with staff members and other physicians of the community.

The correction of these evils, hospital competition in practice and hospital exploitation of doctors, must lie with the doctors themselves. The superintendent has a definitely selfish position to maintain—he has his job to retain—he can be surer of retaining his job by making a good financial showing to his board on which is no representation to protect the doctors' interests. Naturally he will make every endeavor to perpetuate the present system and it is to be regretted that in most instances he is condoned and assisted—at least not opposed—by our profession which is traditionally indifferent to its economic welfare.

Respectfully submitted,
COMMITTEE ON MEDICAL ECONOMICS.
HENRY C. DOZIER, Chairman;
O. O. FEASTER, Secretary;
ROY J. HOLMES,
MOZART A. LISCHKOFF,
WILLIAM C. THOMAS.

After numerous discussions relative to the agreement between the physicians and the FERA, and the methods of handling this work, Dr. O. O. Feaster, Secretary of the Committee, explained that complete details had been published in the January issue of the Florida Medical Journal.

On motion by Dr. Palmer, duly seconded and carried, it was voted to accept the report as read by Dr. Feaster.

Dr. Gordon H. Ira read the following report of the Committee, Advisory to the Woman's Auxiliary:

REPORT OF THE ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY

Your Advisory Committee to the Woman's Auxiliary met with the auxiliary president, Mrs. McMurray, and her cabinet last September at Bartow. As the result of this meeting the following charge of seven points was sent to each auxiliary from our president, Dr. Homer Pearson:

"After a thorough consideration of all work at hand by the board of the Woman's Auxiliary to the State Association in cooperation with the State Advisory Board, I present to you and to each County Auxiliary in the State of Florida the following charge for this year's work, and ask that you and your society cooperate to the

best of your ability with the state officers in their endeavor.

First: Let each member at all times hold herself in readiness to serve on health committees of any outside organization.

Second: Assist in the dissemination of good health literature by means of an enlarged circulation of Hygeia.

Third: Give your wholehearted cooperation to the program of cancer prevention, and arrange if possible one public presentation of cancer prevention material in your county, several if advisable, at a time acceptable to the State Program.

Fourth: Assist in organization of new County Auxiliaries.

Fifth: Hold yourself in readiness to give as wide support as possible when called upon by the State Legislative Committee.

Sixth: Present to as many organizations as possible the talk on 'The Necessity of Health Cards for Household Servants.'

Seventh: Use at least one Study Envelope during the year.

"The time has come when a well organized Woman's Auxiliary in every county can be a great aid to the State Society—therefore we ask for your wholehearted cooperation."

The value of the Woman's Auxiliaries throughout the country is becoming recognized more and more.

Such men as Dr. Olin West, Dr. Chas. Mayo and others have urged that the medical societies not overlook the value of the Woman's Auxiliary, and your advisory committee is of the opinion that there is an unharnessed power in this organization that can be of great value to our society in the future, especially with the legislative program that has been outlined. The state-wide work of the auxiliary in several states speaks for itself.

We have all been interested in the Basic Science Law battle that has been going on in Oregon, and may I quote one paragraph from an article appearing in "Northwest Medicine": "Intensive participation in the fight against the proposed healing arts amendment to the Oregon state constitution, which resulted in its defeat at the November 6th election by a majority of more than 115,000 is cause for justifiable pride this fall to the Woman's Auxiliary to the Oregon State Medical Society. For eight busy months preceding the election, the auxiliary women were untiring in their efforts to defeat the amendment which would, if passed, have defeated in effect the important basic science law passed by the 1933 legislature. Throughout the entire eight months' fight the women of the medical auxiliary treated the campaign as an educational issue. Their entire program had as its objective the dissemination of information relative to the issues involved in the measure and the disastrous results which might follow its passage."

One of the chief objectives next year of the Woman's Auxiliary will be an expansion program. I have a map here showing in red blocks the existing eight Woman's Auxiliaries, and in blue blocks the 24 possible unorganized societies, there being 32 county societies.

In view of the work of the past year, your committee wishes to recommend two things: First, the cooperation of the state and county societies in organizing new auxiliaries when called upon by the organization chairman of the Woman's Auxiliary to the Florida State Medical Society.

And second, realizing that no organization with work to do can exist and grow without funds, we recommend that the State Association allocate 50c a year per member of the State Society to the treasurer of the State Auxiliary, either from the present dues, or by an increase of 50c a year. Fifty cents a year per doctor will mean very little, but will make a growing, helpful organization out of our Woman's Auxiliary.

Respectfully submitted,

Gordon H. Ira, Chairman:
Eugene G. Peek,
William A. Haggard,
Lauchlin M. Rozier.

It was moved, seconded and carried that the above report be accepted without the allotment of 50 cents per member as recommended.

Due to the absence of Dr. Ralph N. Greene no report was made by the Committee on State Hospitals for Insane.

The report of the Inter-Relationship Committee was read by Dr. Charles D. Cleghorn, for Dr. Rowlett, as follows:

REPORT OF THE INTER-RELATIONSHIP COMMITTEE

Your Committee is pleased to report a very successful and active year. In addition to a number of get-together meetings of local physicians, dentists and druggists, there was held in Orlando on February 7th, a general meeting of

your Inter-Relationship Committee with similar committees appointed by the Dental and Pharmaceutical Associations of the State. In addition to creating a better and more friendly understanding between these three organizations, a very constructive program was mapped out, which is bound to produce much good to the physicians of the state as well as the two above-mentioned organizations.

Through the efforts of the Inter-Relationship Committee, the legislative committees of the Medical, Dental and Pharmaceutical Associations were brought together for a unified legislative program, which is being well supported by all three organizations.

At the annual meeting of the State Dental Association, held last fall in Pensacola, two members of the Florida Medical Association were placed on the program, one of whom was our President, Dr. Homer Pearson. Similar invitations have already been sent to members of our Association to appear on their program at the next meeting of the State Dental Association in Tampa next October. Your Committee believes that the interchanging of speakers among the above-mentioned organizations is a wholesome idea, which will result in a better understanding. Therefore, we recommend that the Florida Medical Association invite at least one member from the Dental and Pharmaceutical Associations to appear on the program at its annual meeting.

Respectfully submitted,

William M. Rowlett, Chairman;
J. Knox Simpson,
Charles D. Cleghorn.

Motion made and seconded that the above report be adopted. Voted and carried.

In the absence of Dr. Flipse, no report was made by the Committee on Tuberculosis and Public Health.

The report of the Committee on Feeble-minded and Venereal Disease Control was read by Dr. Henry Hanson, as follows :

REPORT OF COMMITTEE ON FEEBLE-MINDED AND VENEREAL DISEASE CONTROL

Several efforts have been made to have a meeting of the Committee on Feeble-minded and Venereal Disease Control but due to various circumstances no full meeting has been held.

The Committee has corresponded, discussing various items, and has made recommendations somewhat as follows:

FEEBLE-MINDEDNESS

One member of the Committee recommended a further study of the feeble-minded in a eugenic study of the families concerned. A recommendation was made that such should be sterilized. It is believed that if adequate funds were made available one might go into the disease history of these families, as well as other hereditary traits, thereby determining what offers the most practical approach to a solution of the obscure problem of feeble-mindedness.

VENEREAL DISEASE

In order to accomplish any results in a control of the venereal disease prevalence the Chairman of the Committee suggests that the venereal diseases so-called (syphilis, gonorrhea and chancroid) be placed on the same basis as other communicable disease; that an epidemiological study be made and the same general principles be followed out as in the communicable diseases in general.

Further, the State Medical Association should give consideration to the establishment of clinics for study and treatment of this group of communicable diseases among the indigents. The members of the Medical Association should avoid giving the unfortunate victims the feeling that they are regarded as outcasts. Individuals sick with syphilis, gonorrhea or chancroid should be treated as sick human beings and shown a reasonable amount of sympathy so as to avoid having these unfortunates go to "quacks" who temporize with them until all money is gone. When those in poor financial circumstances fall into the hands of "quacks" the "quack" plays with him until he has received the victim's money, and after that the victim wanders at large and is to a large extent responsible for further dissemination of his communicable disease.

It is recommended that the problem of the feeble-minded and venereal disease control be given more intensive study during the coming year.

Respectfully submitted,

Henry Hanson, Chairman;
J. R. McEachern,
P. L. Dodge.

It was moved and seconded that the above report be adopted. Voted and carried.

Dr. Joseph S. Stewart, Jr., read the following

report of the Committee to Study Contraception and Therapeutic and Eugenic Sterilization:

REPORT OF COMMITTEE TO STUDY CONTRACEPTION AND THERAPEUTIC AND EUGENIC STERILIZATION

1. There are at present no laws regulating birth control in the State of Florida.

2. The Federal Statutes affecting birth control are briefly:

Section 211 of the U. S. Penal Code prohibits sending or receiving by or from the U. S. mails information or supplies pertaining to the prevention of conception. *There are no exemptions.*

Section 245 of the U. S. Penal Code also prohibits sending or receiving, by or from, an express company or other common carrier information or supplies pertaining to the prevention of conception. *There are no exemptions.*

Sections 311 and 312 affect the territories and districts of the U. S. and are even more rigid in their prohibition as they forbid even the *possession* of any article intended for the prevention of conception. *There are no exemptions.*

Violations of these laws are subject to a fine of $2,000 to $5,000 or imprisonment for not more than five years, or both.

3. The National Committee on Federal Legislation for Birth Control, headed by Mrs. Margaret Sanger, is the best known committee crusading for repeal of the present national birth control laws. This is a lay committee. The excellent bill sponsored by this committee has recently been defeated in Congress.

4. During the past several years there has come into being The National Medical Committee on Federal and State Contraceptive Legislation, composed entirely of doctors, and even refusing financial support from any supply house selling contraceptives. This committee is national in scope, having sub-committees in each state. A thorough study is being made of the birth control question by this committee and the conclusions reached and recommendations made are comprehensive, adequate, and dignified.

5. The bill sponsored by the National Committee on Federal Legislation for Birth Control (Margaret Sanger, President), and recently defeated in Congress is as follows:

"Be it enacted by the Senate and House of Representatives of the United States of America in Congress Assembled, That sections 211, 245 and 312 of the Criminal Code, as amended, are each amended by adding at the end thereof the following:

" 'The provisions of this section shall not be construed to apply to any book or information relating to the prevention of conception, or article, instrument, substance, drug, medicine, or thing designed, adapted, or intended solely for the prevention of conception for use (1) by any physicians legally licensed to practice medicine in any State, Territory or the District of Columbia, or by his direction or prescription; (2) by any druggist in filling any prescription of a licensed physician; (3) by any medical college legally chartered under the laws of any State, Territory, or the District of Columbia; or (4) by any hospital or clinic licensed in any State, Territory, or the District of Columbia, except in any State in which such use is prohibited by the law thereof.' "

6. Such a bill meets all the requirements of our profession. It is probable that no further action can be given it before 1937.

7. The following quotation from a report of the National Medical Committee on Federal and State Contraceptive Legislation is herewith inserted as a part of the report of your Committee:

"The failure of previous lay efforts to amend the law indicates that an uniform and formidable medical demand for the exemption of physicians from its provisions will be necessary in overcoming the legislative inertia based on a fear that political reprisals from the opposition might follow such a course. Such amendment is also essential in converting the present illicit and illegal atmosphere surrounding contraception to one of decency and legality; this is the only way to induce physicians to furnish the technical knowledge necessary for successful experimental and clinical research, as well as to permit the dissemination of the results of such investigations to the profession. In such a situation the obvious recourse is the American Medical Association, and the primary and immediate objective of this Committee is to secure its sanction for a comprehensive scientific and legislative program on contraception. In our opinion, such a program to be effective, must include a scientific study of contraceptives and concerted effort to secure satisfactory remedial legislation.

"The necessity of the former is all too clear. No method, mechanical, chemical, biological or combinations of these, uniformly satisfactory under differing anatomical, physiological and

psychological conditions, has so far been developed. The ultimate results of some methods are unknown. Others are known to be attended with grave danger to health and even to life. In the absence of a definite consensus of medical opinion, the great public demand for adequate, safe and sane contraception is being commercially exploited by interests solely concerned in capitalizing it for financial profit. As a result the country is being flooded with thinly veiled advertisements in lay journals making the most extravagant claims for various jellies, powders and suppositories; physicians are constantly receiving circulars urging them to employ various vaginal, intracervical and even intra-uterine stems, buttons and pessaries, or to resort to injections of seminal proteins; and enterprising publishers are selling by the hundreds of thousands books and pamphlets on an alleged sterile period, and the U. S. Patent Office asked to grant patents on various mechanical type calendars for its rapid determination. Such a situation demands an intelligent interest on the part of organized medicine; to fail here is but to furnish another argument to those bent on its destruction. Such interest can be best demonstrated by a study of the whole subject by the Council of Pharmacy and Chemistry of the American Medical Association. It is the only agency that can set up standards to bring order out of chaos, mitigate the veils of commercial exploitation, and furnish the information necessary to enable the medical profession to meet intelligently the current public demand. The public as well as the profession have been painstakingly educated to look to this agency of organized medicine for information concerning drugs and procedures to be used in every branch of medicine. Are they not entitled to authoritative information from this source on standards of efficiency and safety for contraceptive devices and medicaments?

"In view of all the considerations outlined above, the primary and immediate objective of this Committee is to secure the adoption of a resolution urging the American Medical Association to initiate a comprehensive program on contraception by:

"A. Having the Council on Pharmacy and Chemistry or other designated body conduct a study and investigation of contraceptives as to their efficiency, safety, standardization, etc., and by:

"B. Instructing its legal department to take all necessary steps to secure the passage by the Congress of the United States of legislation exempting all the medical phases of contraception from the present statutes."

8. This Committee makes the following recommendations:

A. That no new laws be advocated for birth control in the State of Florida at the present time.

B. That the following resolution be approved:

Whereas, The provisions of Sections 211, 245, 311 and 312 of the U. S. Penal Code dealing with contraception,

1. Seriously reflect on the integrity and probity of the medical profession.

2. Tend, by hampering physicians in private and clinic practice in obtaining supplies, to prevent them from giving adequate contraceptive advice, even in cases where it is necessary to conserve health or life itself.

3. Prevent the publication of all contraceptive information in medical text-books and medical journals, resulting in widespread ignorance on the part of the medical profession on this important and necessary branch of preventive medicine, and interfering with the instruction of medical students and practitioners concerning it.

4. Constitute an unwarranted interference by the Federal Government with the right of each state to control the practice of medicine within its own jurisdiction as it may see fit.

5. Have resulted in the commercial exploitation of the practice of contraception, through taking it out of the hands of the medical profession; and

Whereas, Legislation is now pending in the Congress of the U. S. that, if enacted into law, would make the provisions of the Federal Penal Statutes respecting contraception even more rigorous; and

Whereas, The whole subject is seriously in need of scientific study and investigation, in order that satisfactory standards of effectiveness and safety may be authoritatively set up, thus mitigating the evils of the increasing commercial exploitation of medicaments, devices and procedures often potentially harmful or dangerous to health; and

Whereas, The medical profession and the public have the right to look to the American Medical Association to assume a role of leadership in both the scientific and legal phases of contraception:

THEREFORE BE IT RESOLVED: That the Florida Medical Association requests the House of Delegates of the American Medical Association to initiate a comprehensive program with respect to contraception, instructing its appropriate agencies to undertake the necessary scientific study and to make every legitimate effort to have Federal and State laws so amended as to remove the restrictions now affecting physicians; and that the Secretary be hereby instructed to forward a copy of this resolution to the Secretary of the American Medical Association.

That our delegates to the American Medical Association be instructed to urge and vote for the adoption of such program.

That County Medical Societies of the state be encouraged to devote one program next year to the discussion of contraception.

Your Committee feels that the time is not right, nor sentiment sufficiently strong, for further action on state laws for eugenic sterilization at this time.

COMMITTEE TO STUDY CONTRACEPTION AND THERAPEUTIC AND EUGENIC STERILIZATION.

JOS. S. STEWART, Chairman;
LEIGH F. ROBINSON,
JOSEPH H. RUTTER.

It was moved and seconded that the above report be adopted. Voted and carried.

Dr. Pearson mentioned a letter from the Governor to Dr. Rowlett last year, in which he stated that he would like to see the convention of the American Medical Association held in Florida. Dr. Pearson stated that this matter had been taken up but that there was no possible place in Florida where this convention could be held except Miami, and that Miami did not have an auditorium suitable for the meetings. Miami hopes to have an auditorium of sufficient size within the near future, but that will be one or two years hence.

Dr. Henry Hanson asked permission to bring up the matter of an invitation to the American Public Health Association. This was referred to the House of Delegates.

The following telegram was read by the President:

"Dr. Homer L. Pearson, President Florida State Medical Association—in annual meeting assembled:

Greetings and good wishes. I hope you are having a most successful annual meeting. Under the Presidency of your own Dr. H. Mashall Taylor we anticipate our St. Louis Meeting this November will be the most successful one we have ever had and expect a large number of your good Florida Doctors to be with us on that occasion.

C. P. Loranz, Southern Medical Association."

The following recommendations were read by the President, Dr. Homer L. Pearson:

"I believe it is customary for the president to make certain recommendations to the Association concerning the work for the coming year and I believe it might be well to make those recommendations now.

"Heretofore the Committee on Legislation and Public Policy has not had a great deal to do on off-legislative years, or during the year that the Legislature is not in session. I feel that during those years particularly, the Legislative Committee should serve also as a political committee. It should be a rather large committee, with representatives from all parts of the state whose duty it would be to furnish the Association with the lists of candidates for every office throughout the state, and to list their qualifications, to obtain from the candidates themselves a statement relative to their feelings concerning the medical profession, or if they are in sympathy with the legislative program of our Association. Then, too, they should instruct the Association as to which candidates we should support. The committee serving in this capacity would be of inestimable value to the Association and would simplify the work of the Committee a great deal in legislative years.

"The maternal mortality rate of the United States is as high as that of any civilized nation. The maternal mortality rate of the State of Florida was higher than that of any other State in the Union. It is my understanding that this rate has been materially lowered this year, however. When the above astounding facts are made known it is the disposition of a great many of us to try to explain why; in other words, to make excuses for it, such as inaccurate statistics and an unusually large number of poor maternal risks or women who should not be allowed to attempt child-bearing and, too, we say that the lax laws of Florida allow almost anyone to assume the responsibility of caring for the mother at the time of her confinement. We really do feel, and expect to manifest that feeling, that too many Florida women receive poor care at this important event in their lives. Be that as it may, the

fact still remains that Florida has one of the highest maternal mortality rates in the nation. That is a serious indictment against those practicing midwifery in this state. It is so serious that the Florida Medical Association should take definite steps to lower that rate.

"Therefore, to work with the American Committee on Maternal Welfare, I wish to recommend the appointment by the President of this Association, a permanent Committee of the Florida Medical Association on Maternal Welfare. One member should be appointed from each congressional district of the state. These men must be picked with great care. They must not only be enthusiastic but must be willing to work, for if the committee is to do any real good it will take a great deal of hard work. There are committees such as this from nearly all the State Medical Associations and their duty now is to investigate and analyze all the maternal deaths in their respective states. This committee would make an annual report to the Association as do the other committees of the Association. I feel that it is imperative that such a committee be named."

There being no further business, the meeting adjourned.

FIRST MEETING OF THE HOUSE OF DELEGATES

The House of Delegates convened at 8:00 p. m. Monday, May 13th, in the Dixie Theatre.

Call to order by the President, Dr. Homer L. Pearson.

Roll call by the Secretary showed the following delegates present:

DELEGATES

Alachua County Medical Society—
J. M. Dell, Sr.

Brevard County Medical Society—
W. C. Page

Broward County Medical Society—
Leigh F. Robinson

Columbia County Medical Society—
T. H. Bates

Dade County Medical Society—
Walter C. Jones
Warren Quillian
Carl Dunaway
Joe S. Stewart
Roy Holmes
Gerard Raap

DeSoto-Hardee-Highlands County Medical Society—
L. W. Martin

Duval County Medical Society—
J. Knox Simpson
C. B. Mabry
L. Y. Dyrenforth
Ferdinand Richards
J. B. Black

Escambia County Medical Society—
M. A. Lischkoff

Hillsboro County Medical Society—
Bundy Allen
J. W. Taylor
J. W. Alsobrook
H. Mason Smith

Lake County Medical Society—
W. L. Ashton

Lee County Medical Society—
H. Quillian Jones

Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society—
J. H. Pound

Manatee County Medical Society—
H. Gates

Marion County Medical Society—
Eugene G. Peek

Orange County Medical Society—
H. A. Day
C. D. Christ
C. J. Collins

Palm Beach County Medical Society—
W. L. Shackelford
W. Y. Sayad
W. J. Buck

Pasco-Hernando-Citrus County Medical Society—
George A. Dame

Pinellas County Medical Society—
O. O. Feaster
J. A. Strickland
A. L. Mills
H. E. Winchester

Polk County Medical Society—
R. L. Cline
J. R. Boulware, Jr.
J. L. Hargrove

St. Johns County Medical Society—
H. E. White

St. Lucie-Okeechobee-Indian River-Martin County Medical Society—
E. B. Hardee

Seminole County Medical Society—
H. D. Smith

Sumter County Medical Society—
S. C. Wood

Volusia County Medical Society—
Hugh West

Walton-Okaloosa County Medical Society—
C. W. McDonald

Bay, Jackson, Madison, Monroe, Putnam, Sarasota and Taylor County Medical Societies were not represented.

The first order of business was the adoption of the minutes of last year's meeting. Motion made and seconded that the minutes be adopted as published in the May, 1934 Journal. Voted and carried.

Dr. Pearson called for the nomination of one delegate and one alternate to the American Medical Association meeting for two-year terms.

Dr. Meredith Mallory was nominated by Dr. Bundy Allen as a delegate to the A. M. A. for a two-year term, seconded by Drs. C. D. Christ and H. Mason Smith. It was moved and seconded that the nomination be closed and Dr. Meredith Mallory appointed delegate. So ordered.

Dr. W. J. Buck then nominated Dr. C. D. Christ alternate delegate to the A. M. A. for a two-year term. It was moved, seconded and car-

ried that the nominations be closed and Dr. Christ appointed alternate delegate.

The two proposed amendments to the constitution presented at the 1934 meeting were read as follows:

1. That the first sentence of Article VI, Section 2, be amended to read:

"The Association shall hold an Annual Meeting at a place selected by the outgoing Executive Committee."

2. That Article VII, Section 2, be amended to read:

"All officers of this Association shall be elected by the House of Delegates at its last session and the names of the new officers shall be announced to the Association at its last general session."

There was a standing vote of 21 to 18 in favor of the first amendment. (Two-thirds majority required).

Following the reading of the second proposed amendment, Dr. Dell offered a motion for roll call vote to include both proposed amendments as above quoted. Seconded and carried.

Ayes—Dell, Page, Allen, H. Mason Smith, Gates, Day, Christ, Collins, Shackelford, Dame, Feaster, Strickland, Mills, Winchester, Wood—15.

Nays—Robinson, Bates, W. C. Jones, Quillian, Dunaway, Stewart, Holmes, Raap, Martin, Simpson, Richards, Dyrenforth, Lischkoff, Taylor, Alsobrook, Ashton, H. Q. Jones, Pound, Peek, Sayad, Buck, Cline, Boulware, Hargrove, White, Hardee, H. D. Smith, West, McDonald—29.

Twenty-nine votes in opposition to fifteen in favor. Both amendments lost.

Motion made by Dr. J. M. Dell, Sr., that the above vote be reconsidered. Dr. Dell's motion received a standing vote of 21 against 17. A second roll call vote was ordered.

Ayes—Robinson, W. C. Jones, Quillian, Dunaway, Stewart, Simpson, Dyrenforth, Richards, Black, Lischkoff, Pound, Gates, Christ, Shackelford, Sayad, Buck, Feaster, Strickland, Mills, Winchester, Cline, Boulware, Hargrove, White, Hardee—25.

Nays—Dell, Page, Bates, Raap, Holmes, Martin, Allen, Taylor, Alsobrook, H. Mason Smith, Ashton, H. Q. Jones, Peek, Day, Collins, Dame, H. D. Smith, Wood, West, McDonald—20.

There were twenty-five votes in favor of the amendment and twenty opposed. However, due to an insufficient majority, the amendment was lost.

A resolution to amend the By-Laws of this Association was read by Dr. H. A. Day, who was requested to present same at the next open session.

Dr. H. Mason Smith, Chairman pro tem of the Committee on State Hospitals for the Insane in the place of Dr. Ralph N. Greene, requested permission to present the committee's report at this session.

Upon motion duly made, seconded and carried, Dr. H. Mason Smith read the following report:

REPORT OF COMMITTEE ON STATE HOSPITALS FOR INSANE

Your Committee on State Hospitals for the Insane regrets very much to report the illness of Chairman Ralph Greene since March first, which has prohibited his activities in the interest of this committee and the Florida Medical Association. Since Dr. Greene's illness, H. Mason Smith has been designated as Chairman pro tem, and has been serving as Chairman of this Committee.

The major purpose of this committee was to sponsor and encourage the creation of a new State Hospital for the Insane in the peninsular section of the state. Very little encouragement was obtained from the members of the state Legislature prior to the convening of the present session. In the early part of the present session considerable encouragement was obtained by the committee from the fact that the Legislature is endeavoring to use some of the government's funds in the construction of extensions at Chattahoochee or the creation of a new hospital.

It has been a matter of general knowledge that the present State Hospital is so crowded that the admission of patients has been limited to a very few of the worst type of mental cases since January 1st. The lay superintendent of the State Hospital at Chattahoochee has asked for a million dollars for extension at that institution. The medical staff of the State Hospital at Chattahoochee has recommended the creation of another institution in the southern part of the state instead of making extensions to the plant at Chattahoochee.

Further encouragement has been obtained by the fact that Representative Lea of Manatee County has introduced a bill in the House to purchase the properties at Sun City, Florida, which is situated 30 miles south of Tampa and 20 miles north of Bradenton, for the purpose of establishing there a Hospital for the insane. The purchase price of this property is incorporated in the bill. (Note amendment by House of Delegates). Your committee has been anxious for this bill to go through as there are buildings al-

ready constructed on this property which can easily be converted for immediate admission of insane patients and the passage of this bill would save three or four years in obtaining a hospital. That is, if a bill merely provides for the creation of an institution and leaves the location and the construction of buildings to the Board of Commissioners of State Institutions, it will require three or four years to build the institution and have it ready for the reception of patients.

The members of the House and Senate sponsoring this bill have promised both the President and this Committee that the Medical Association would have a hearing before the joint committee dealing with this bill at the time when it is considered; such committee action, however, has not yet been taken.

COMMITTEE ON STATE HOSPITALS FOR INSANE.
H. MASON SMITH, Chairman *pro tem;*
H. A. DAY,
GEORGE M. DAWSON.

Dr. Christ disagreed with that portion of the above report relative to the purchase by the state of a specified tract of land on which to construct the proposed new State Hospital for the Insane.

Dr. H. A. Day, a member of the committee, discussed the report briefly, stating that he was in favor of the report except for that portion which specified a definite location and price.

Upon motion made and seconded the report was voted but not accepted.

Dr. H. Mason Smith announced that the legislature had promised the Association a hearing on this proposition, and he offered the motion that this Association request them to build this hospital in the peninsular part of the state.

Motion seconded by Dr. Eugene Peek. Motion carried.

Dr. Hardee proposed an amendment to include a general and a tubercular hospital. Amendment not accepted.

Dr. Pearson then called for a standing vote on the committee's report, which was unanimously accepted as amended.

Motion made, seconded and carried that Dr. H. Mason Smith's amendment be accepted and that the Association ask that this hospital be built in the peninsular portion of the state—but not to combine this with the general and tubercular hospital, as proposed by Dr. Hardee.

Dr. Jos. S. Stewart, Chairman, read the following resolution of the Committee to Study Contraception and Therapeutic and Eugenic Sterilization:

Whereas, The provisions of Sections 211, 245, 311 and 312 of the U. S. Penal Code dealing with contraception,

1. Seriously reflect on the integrity and probity of the medical profession,
2. Tend, by hampering physicians in private and clinic practice in obtaining supplies, to prevent them from giving adequate contraceptive advice, even in cases where it is necessary to conserve health or life itself,
3. Prevent the publication of all contraceptive information in medical text-books and medical journals, resulting in widespread ignorance on the part of the medical profession on this important and necessary branch of preventive medicine, and interfering with the instruction of medical students and practitioners concerning it,
4. Constitute an unwarranted interference by the Federal Government with the right of each State to control the practice of medicine within its own jurisdiction as it may see fit,
5. Have resulted in the commercial exploitation of the practice of contraception, through taking it out of the hands of the medical profession; and

Whereas, Legislation is now pending in the Congress of the U. S. that, if enacted into law, would make the provisions of the Federal Penal Statutes respecting contraception even more rigorous; and

Whereas, The whole subject is seriously in need of scientific study and investigation, in order that satisfactory standards of effectiveness and safety may be authoritatively set up, thus mitigating the evils of the increasing commercial exploitation of medicaments, devices and procedures often potentially harmful or dangerous to health; and

Whereas, The medical profession and the public have the right to look to the American Medical Association to assume a role of leadership in both the scientific and legal phases of contraception:

THEREFORE BE IT RESOLVED: That the Florida Medical Association requests the House of Delegates of the American Medical Association to initiate a comprehensive program with respect to contraception, instructing its appropriate agencies to undertake the necessary scientific study and to make every legitimate effort to have Federal and State laws so amended as to remove the restrictions now affecting physicians; and that the Secretary be hereby instructed to forward a copy of this resolution to the Secretary of the American Medical Association.

BE IT FURTHER RESOLVED: That our delegates to the American Medical Association be instructed to urge and vote for the adoption of such program.

Motion made, seconded and carried that this resolution be adopted as read.

The following resolution was presented by Dr. E. B. Hardee:

"BE IT RESOLVED: That the Florida Medical Association hereby expresses its disapproval of any of its members in making initial examinations for life insurance applicants at a fee of less than $5.00.

"BE IT RESOLVED: That the Florida Medical Association approves the exaction of a fee of not less than $5.00 for a report to any insurance company referable to the physical or mental condition of an applicant for insurance or a disability claim."

Motion made, seconded and carried that the resolution be adopted as read.

The following resolution was read by Dr. Quillian and unanimously adopted:

"Be It Resolved: That the President of the Florida Medical Association appoint a permanent committee to study problems concerning maternal and infant mortality in Florida."

Dr. M. A. Lischkoff offered a motion that the Florida Medical Association appoint two delegates to the Alabama Medical Association meeting, to exchange delegates with the Alabama Medical Association as has been the custom with the Georgia Medical Association. Seconded and carried.

The next order of business being the selection of a meeting place for 1936, Dr. J. Knox Simpson of Jacksonville submitted literature from the P. & O. Steamship Co., and moved that the Association charter the S.S. Florida for a cruise among the Bahama Islands, the meetings to be held on board ship.

Dr. O. O. Feaster extended a most cordial invitation from the Pinellas County Medical Society that the Association meet in St. Petersburg next year.

After much discussion a rising vote resulted in 25 for the boat trip and 20 for St. Petersburg.

It was moved, seconded and carried that a roll call vote be ordered to reconsider the selection of a meeting place for 1936, which resulted as follows:

Boat trip—Robinson, Bates, W. C. Jones, Quillian, Dunaway, Stewart, Holmes, Raap, Simpson, Mabry, Dyrenforth, Richards, Black, Lischkoff, Allen, J. W. Taylor, Pound, Gates, Day, Collins, Buck, H. E. White, Hardee, West —24.

St. Petersburg—Dell, Page, L. W. Martin, Alsobrook, H. Mason Smith, Ashton, H. Q. Jones, Peek, Christ, W. L. Shackelford, Sayad, George Dame, Feaster, Strickland, Mills, Winchester, Cline, Boulware, Hargrove, H. D. Smith, Wood, McDonald, Richardson—23.

Dr. Pearson, speaking for the Dade County Medical Society, extended an invitation to the Association to hold the 1936 annual meeting in Miami in the event a minimum of three hundred reservations were not made and the boat trip had to be cancelled.

On motion duly seconded and carried, Dade County's invitation was accepted, subject to the cancellation of the boat trip.

There being no further business, on motion made, seconded and carried, the meeting adjourned.

FIRST SCIENTIFIC ASSEMBLY

The Scientific Assembly convened at 9:00 a. m., Tuesday, May 14th, in the Dixie Theatre, with Dr. G. S. Osincup presiding.

The following papers were read and discussed.

1. "Friedman Test for Pregnancy. Report of Two Hundred Cases," Dr. Herbert R. Mills, Tampa.
2. "Obstetrical Liabilities," Dr. Samuel R. Norris, Jacksonville.
3. "Maternal Mortality," Dr. Henry Hanson, Jacksonville.

SECOND GENERAL SESSION

The General Assembly reconvened at 10:30 a. m., May 14th, in the Dixie Theatre, with Dr. Homer L. Pearson in the Chair.

Meeting called to order.

The following report of the Secretary-Treasurer-Editor and Business Manager was read by Dr. Shaler Richardson:

JOINT REPORT OF SECRETARY-TREASURER, EDITOR OF THE JOURNAL, DR. SHALER RICHARDSON, AND BUSINESS MANAGER, DR. STEWART G. THOMPSON

To The President and Members of the Florida Medical Association in Session at Ocala.

Gentlemen:

MEMBERSHIP

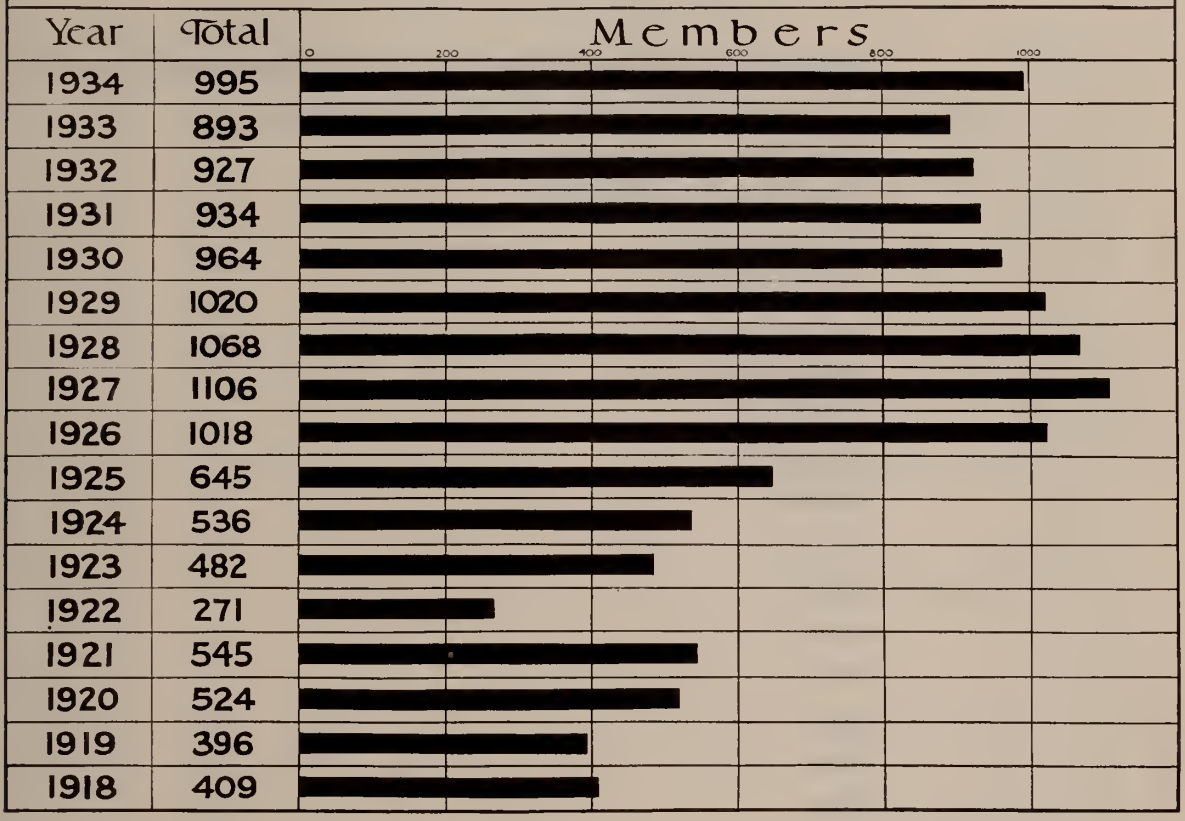
There was a net increase of 102 paid members in the Association for 1934 as compared with the previous year. For the calendar year 1934, there were 995 paid members as compared with 893 for 1933.

The Dade County Medical Society held first place in the number of paid members for 1934, having a total of 194. This is the third consecutive year that this society has held first place in total paid memberships. Duval County Medical Society was second with a total of 141. The Hillsboro County Medical Society held third place and has reached the over-one-hundred class, having a paid membership of 106 for 1934 as compared with 84 for the previous year.

For the calendar year 1934, there were twenty-three component societies showing 100% of their membership dues paid. They were: Alachua, Columbia, Dade, Hillsboro, Lee, Leon-Gadsden-Liberty-Wakulla-Jefferson, Madison, Manatee, Marion, Monroe, Orange, Palm Beach, Pasco-Hernando-Citrus, Pinellas, Putnam, St. Johns, St. Lucie-Okeechobee-Indian River-Martin, Sarasota, Seminole, Sumter, Taylor, Volusia, and Walton-Okaloosa. This appears to

FLORIDA MEDICAL ASSOCIATION, INC.

Total members who have paid state dues
1918 to 1934 inclusive



be the best record made so far. Of the 32 component societies, 23 show 100% of State dues paid for 1934, with six of the remaining societies having only one member each in arrears. This means that only three county societies out of a total of 32 had more than one member in arrears for 1934.

The number of members dropped in 1934, because of death, moving from the State, or failure to pay State dues, totaled 24 as compared with 52 for the previous year. This comparison is, indeed, very encouraging.

JOURNAL

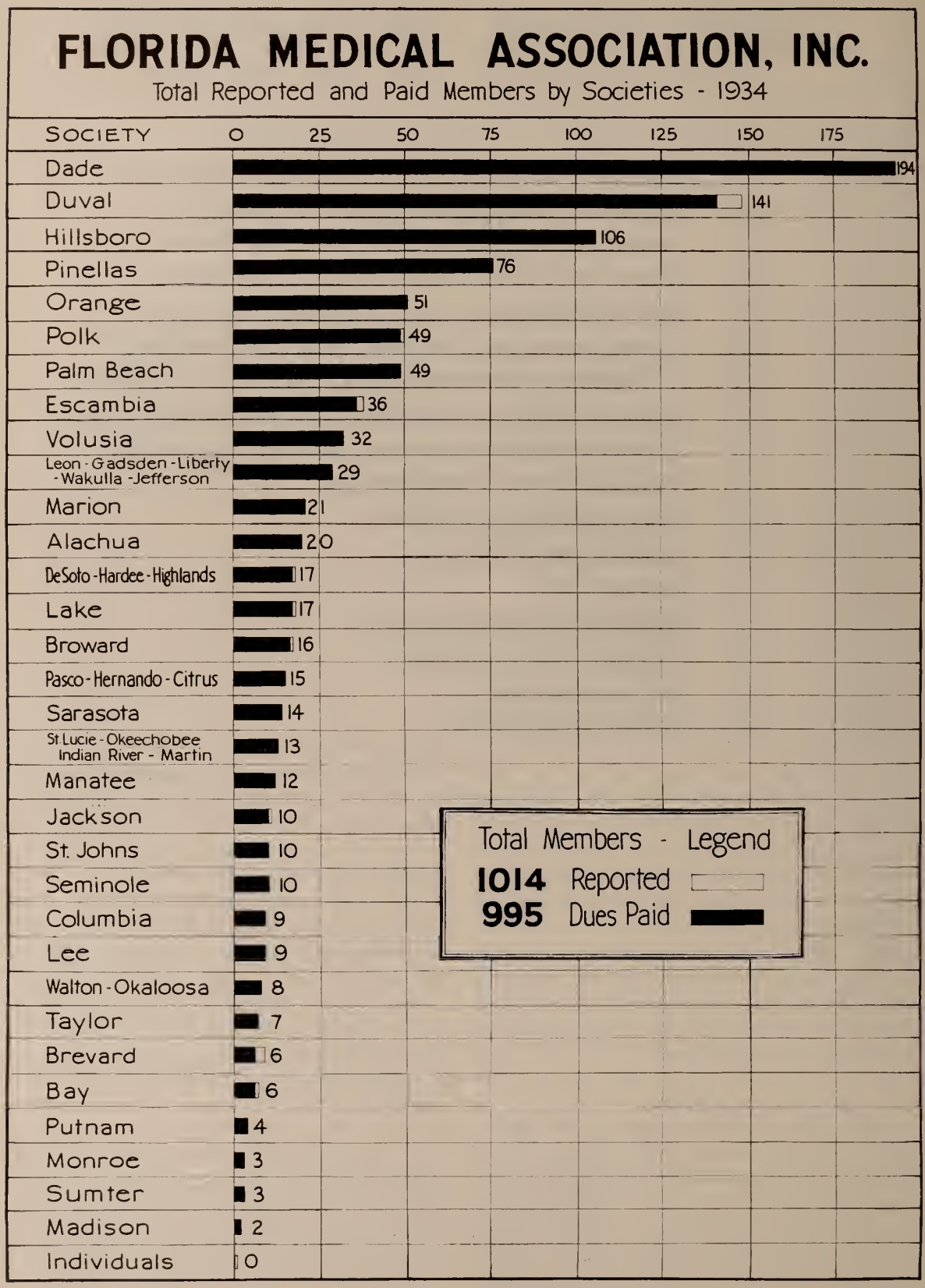
During the year, 14,892 Journals were mailed from the business office. This direct mailing of the Journal saves considerable expense and is of great assistance in keeping an up-to-date mailing list of members, advertisers and subscribers. The cost of printing the Journal has not varied during the past year although the printer has advised us that the cost of production has slightly increased.

The Record Company of St. Augustine have printed the Association's Journal for many years and their work has been high-class and entirely satisfactory. We desire to highly compliment those in this concern who are responsible for this splendid cooperation and good work.

The Committee on Publication has rendered a real service to the members of our Association in so faithfully reading and editing scientific papers before they were accepted for publication. Dr. Walter Jones of Miami and Dr. Herbert White of St. Augustine have given generously of their time and have been unusually prompt in returning papers after they were mailed out for review.

FINANCES

The net increase of receipts over disbursements for the past year was $1,644.47 as compared with $2,729.96 for the previous year. This, however, is a very good showing since the figures for the previous year were based on annual dues of $10.00 as compared with $7.50 for last year. This net gain of $1,644.47 was accomplished by very careful expenditures during the entire year and also due to the fact that your secretary-treas-


FLORIDA MEDICAL ASSOCIATION, INC.
Total Reported and Paid Members by Societies - 1934
SOCIETY
0
25
50
75
100
125
150
175
Dade 194
Duval 141
Hillsboro 106
Pinellas 76
Orange 51
Polk 49
Palm Beach 49
Escambia 36
Volusia 32
Leon - Gadsden - Liberty - Wakulla - Jefferson 29
Marion 21
Alachua 20
DeSoto - Hardee - Highlands 17
Lake 17
Broward 16
Pasco - Hernando - Citrus 15
Sarasota 14
St Lucie - Okeechobee Indian River - Martin 13
Manatee 12
Jackson 10
St. Johns 10
Seminole 10
Columbia 9
Lee 9
Walton - Okaloosa 8
Taylor 7
Brevard 6
Bay 6
Putnam 4
Monroe 3
Sumter 3
Madison 2
Individuals 0
Total Members - Legend
1014 Reported
995 Dues Paid

urer and editor of the Journal is serving without salary. Letterheads, envelopes, mimeograph paper and other office supplies were bought only after several bids were taken. Advantage was taken of every opportunity to save money and operate the business office on an economical basis.

During the year, there was an income of $2,738.06 from advertising as compared with $2,481.73 for the previous year. Three years ago, only $2,240.60 was received through this source. This small but steady increase in the earnings from advertising has supplemented the income of the Association and helped to keep our income above expenses.

At the last annual meeting held in Jacksonville, seventeen exhibit spaces were sold, representing a total of $770.00. At the Hollywood annual meeting the previous year, eight spaces were sold for $295.00. Sixty per cent of the total income from the sale of exhibit spaces is turned over to the entertaining society to defray convention expenses. Forty per cent of the income from exhibit sales goes into the Association treasury to take care of expenses in connection with the annual meeting and to cover the expense of selling exhibit spaces and looking after exhibitors. There is considerable expense in the way of letter-writing, postage, supplies, etc., when a campaign is put on for the sale of exhibit spaces. One experienced clerk is necessary on the registration desk and the traveling expenses for this service is taken from the sale of exhibit spaces.

The managements of the headquarters hotels have cooperated with your officers. Advertising space is given in the Journal for the hotel and in return the hotel furnishes hotel rooms for the guest speaker, business manager, registration desk clerk, and the stenographer who takes the proceedings of the meetings. The hotel also builds the skeleton booths for exhibitors. This entire expense in connection with the annual convention is received from the management on a trade basis for advertising in the Journal. This, as you see, does not take cash out of our treasury.

The books and records of the Association are open to our members and we will be glad to answer inquiries of any nature. The books have been audited by Ford, Boyd & Colley, and a certification thereof is incorporated in the statements which follow.

Respectfully submitted,

SHALER RICHARDSON,
STEWART G. THOMPSON.

FORD, BOYD & COLLEY
CERTIFIED PUBLIC ACCOUNTANTS

Jacksonville, Fla., May 11, 1935.

Dr. Shaler A. Richardson,
Treasurer, Florida Medical Association,
Jacksonville, Florida.

DEAR SIR:

We have examined the attached statements of Cash Receipts and Disbursements of the Florida Medical Association for the period begun April 17, 1934, and ended April 22, 1935, both inclusive. These statements have been prepared by Dr. S. G. Thompson, Business Manager of the Florida Medical Association and the Florida Medical Journal, and correctly reflect the total amounts received and disbursed as shown by the books.

In accordance with your instructions, we have checked the total of the collections shown by the statements with the corresponding total shown by the books and have found them to be in agreement.

Cancelled bank checks were examined and compared with the corresponding entries in the cash journal; the additions of the cash journal were checked and all postings were checked to the general ledger. The general ledger additions were checked and a trial balance taken off as of April 22, 1935.

Bank accounts were reconciled with bank statement and pass book, and confirmations were obtained from the bankers.

As we do not have access to the records of the various County Societies for the purpose of checking the remittances of dues, attention is directed to Exhibits D and F, which give details as to this matter. The inspection of these exhibits by the officers of the respective societies will enable them to verify the correctness of the remittances shown.

Income from Journal advertising was verified substantially by comparison with a statement of the contracts with advertisers.

The ten United States Treasury Bonds, par value $1,000.00 each, (interest rate 3⅜%) were verified by us with the Atlantic National Bank.

Yours very truly,
FORD, BOYD & COLLEY.

CONSOLIDATED CASH STATEMENT
April 17, 1934, through April 22, 1935

Receipts

Cash in Bank, April 17, 1934		$14,665.80
Dues Collected (Exhibit "D")	$ 7,552.50	
Earnings from Advertising (Exhibit "E")	2,738.06	
Subscription and Miscellaneous Sale of Journal	21.15	
Bonus from Cooperative Medical Adv. Bureau	110.02	
Interest on Savings and Investment	537.55	
Earnings—Technical Exhibits (Exhibit "C")	447.50	11,406.78
Total Cash to be Accounted for		$26,072.58

Disbursements

General Fund Expenses (Exhibit "A")	$ 4,038.96	
Journal Expenses (Exhibit "B")	4,689.32	
Technical Exhibit Expenses (Exhibit "C")	$132.89	
To Entertaining Societies	268.50	401.39
Committee Expenses	472.63	
Furniture and Fixtures	128.75	
Library	18.80	
Federal Tax	12.16	9,762.01
Balance in Bank, April 22, 1935		$16,310.57

EXHIBIT "A"
CASH STATEMENT—GENERAL FUND
April 17, 1934, through April 22, 1935

Receipts

Cash as per last audit		$14,031.09
Back Dues Collected (Exhibit "D")	$1,207.50	
Current Dues Collected (Exhibit "D")	6,345.00	7,552.50
Interest on Savings and Investment		537.55
Total Cash to be Accounted for		$22,121.14

Disbursements

Postage and Supplies	$ 283.72	
Telephone and Telegraph	156.66	
Salaries	3,048.00	
Convention Expense	124.94	
Office Rent	180.00	
Legal Counsel	100.00	
Auditing Expense	12.50	
Messenger Service	4.95	
Bond of Treasurer	18.75	
Custody of Bonds	10.00	
Reprints, Constitution and By-Laws	16.85	
Newspaper Releases	10.00	
Incidental Expense	69.98	
Bank Exchange	2.61	$4,038.96
Committees:		
Post-Graduate Course	19.89	
Medical Economics	15.82	
Program	1.50	
Public Relations	8.55	
Legislative	426.87	472.63
Furniture and Fixtures	128.75	
Library	18.80	
Federal Tax	12.16	
To Journal Fund (Difference Between $3.00 per member and cost of Journal)	1,820.09	6,491.39
Cash Balance		$15,629.75

EXHIBIT "B"
CASH STATEMENT—JOURNAL FUND
April 17, 1934, through April 22, 1935

Receipts

As per last audit		0.00
Earnings from Advertising (Exhibit "E")	$2,738.06	
Subscription and Miscellaneous Sale of Journal	21.15	
Bonus from Cooperative Med. Adv. Bureau	110.02	
From General Fund	1,820.09	
To be Accounted for		$4,689.32

Disbursements

Postage and Supplies	$ 188.98	
Telephone and Telegraph	54.49	
Printing of Journal and Electrotypes	2,816.47	
Salaries	1,572.98	
Auditing Expense	12.50	
Bond of Treasurer	18.75	
Drayage	12.00	
Messenger Service	7.55	
Incidental Expense	5.60	4,689.32
Cash Balance		$ 0.00

EXHIBIT "D"
DUES COLLECTED APRIL 17, 1934, THROUGH APRIL 22, 1935

Name of Society	Total Members	No. Paid Members	No. in Arrears	1935 Dues Collected	Back Dues Collected
Alachua	21	18	3	$ 127.50	$ 32.50
Bay	10	8	2	52.50	7.50
Brevard	8	4	4	22.50	7.50
Broward	21	20	1	142.50	
Columbia	8	8	0	52.50	7.50
Dade	207	172	35	1,282.50	247.50
DeSoto-Hardee-Highlands	19	19	0	135.00	22.50
Duval	143	90	53	667.50	245.00
Escambia	37	12	25	82.50	90.00
Hillsboro	117	106	11	787.50	37.50
Individuals	3	0	3		
Jackson	12	10	2	67.50	
Lake	19	18	1	127.50	7.50
Lee	10	9	1	60.00	
Leon-Gadsden-Liberty-Wakulla-Jefferson	34	27	7	195.00	52.50
Madison	3	3	0	15.00	
Manatee	12	9	3	60.00	7.50
Marion	19	19	0	135.00	22.50
Monroe	3	0	3		
Orange	52	50	2	367.50	52.50
Palm Beach	52	52	0	382.50	105.00
Pasco-Hernando-Citrus	13	13	0	90.00	7.50
Pinellas	79	71	8	525.00	22.50
Polk	57	52	5	382.50	30.00
Putnam	7	4	3	22.50	15.00
St. Johns	11	11	0	75.00	7.50
St. Lucie-Okeechobee-Indian River-Martin	13	1	12	7.50	22.50
Sarasota	15	14	1	97.50	22.50
Seminole	10	10	0	67.50	
Sumter	5	5	0	37.50	22.50
Taylor	6	6	0	37.50	
Volusia	38	28	10	202.50	112.50
Walton-Okaloosa	6	6	0	37.50	
Totals	1,070	875	195	$6,345.00	$1,207.50

$1,207.50 Back Dues Collected

$7,552.50 Total Dues Collected

EXHIBIT "C"
CASH STATEMENT—EXHIBIT FUND
April 17, 1934, through April 22, 1935

Receipts

Cash as per last audit		$ 634.71
Earnings from Technical Exhibits		447.50
Total Cash to be Accounted for		$1,082.21

Disbursements

Telephone and Telegraph	$ 2.22	
Salaries	11.50	
Drawing, Printing, Sign Painting, etc.	70.32	
Convention Expense	47.50	
Drayage	1.00	
Incidental Expense	.35	$132.89
To Entertaining Society (Duval—$104.25 plus $17.25 refunds on banquet tickets, etc.)		121.50
To Entertaining Society (Marion)		147.00
		401.39
Cash Balance		$ 680.82

EXHIBIT "E"
EARNINGS FROM ADVERTISING
April 17, 1934, through April 22, 1935

May, 1934	$ 160.75
June	160.01
July	167.78
August	253.03
September	203.05
October	275.77
November	247.33
December	239.32
January, 1935	214.42
February	263.96
March	190.15
April	362.49
Total	$2,738.06

EXHIBIT "F"
NAMES OF MEMBERS DROPPED BY REASON OF REMOVAL, NON-PAYMENT OF DUES, ETC.
April 17, 1934, through April 22, 1935

Name and Address.	Dues Not Paid 1934	1935
ALACHUA COUNTY MEDICAL SOCIETY:		
Haskell, Lyman G., Gainesville	7.50	
BAY COUNTY MEDICAL SOCIETY:		
Blackshear, W. J., Panama City	7.50	7.50
BREVARD COUNTY MEDICAL SOCIETY:		
Hay, I. M., Melbourne	7.50	7.50
Potthoff, E. W., Titusville	7.50	7.50
White, Charles B., Cocoa	7.50	7.50
BROWARD COUNTY MEDICAL SOCIETY:		
Johnston, John A., Ft. Lauderdale	7.50	
DADE COUNTY MEDICAL SOCIETY:		
Deederer, Carleton, Miami	7.50*	
Maxwell, L. H., Ft. Lauderdale	7.50	
Payne, J. W., Monticello, Ga.	7.50	
Strong, C. J., Miami	7.50*	
Strong, C. J., Miami (Died after being reinstated)	7.50	
DESOTO-HARDEE-HIGHLANDS COUNTY MEDICAL SOCIETY:		
Eide, A. T., Lake Placid	7.50*	
DUVAL COUNTY MEDICAL SOCIETY:		
Bacon, Henry, Jacksonville	7.50	
Enneis, F. B., Jacksonville	7.50	
Jones, F. C., Jacksonville	7.50	
Milam, Ernest B., Jacksonville	7.50	
Morgan, Thomas E., Jacksonville	7.50	
Proctor, Harper L., Jacksonville	7.50	
Weaver, W. N., University, Va.	7.50	
Wilson, J. Frank, Jacksonville	7.50	
ESCAMBIA COUNTY MEDICAL SOCIETY:		
D'Alemberte, C. W., Pensacola	7.50	7.50
Stokes, T. H., Pensacola	7.50	7.50
INDIVIDUALS:		
Simmons, S. J., Belle Glade	7.50*	
JACKSON COUNTY MEDICAL SOCIETY:		
Gainey, J. C., Blountstown	7.50	7.50
LAKE COUNTY MEDICAL SOCIETY:		
Coupland, James D., Eustis	7.50*	
MARION COUNTY MEDICAL SOCIETY:		
Curry, J. F., Dunnellon		7.50
POLK COUNTY MEDICAL SOCIETY:		
Gilchrist, J. G., Bartow	7.50*	
Glennan, Thomas L., Bartow	7.50	
Weed, Walter L., Lakeland (Transferred to Orange Co.)	7.50*	
	$210.00	$ 60.00
Dues of Secretaries		217.50
	210.00	277.50
		210.00
Total		$487.50

*Reinstated.

ASSETS AND LIABILITIES
April 22, 1935

Assets

Cash in Bank	$ 8,157.77
General Fund—Accounts Receivable	1,462.50
Furniture & Fixtures (Less depreciation)	288.36
Library	139.90
Stationery Inventory	98.19
Savings—Barnett National Bank	8,152.80
Investment (Treasury Bonds)	10,178.13
	$28,477.65

Liabilities

Journal—Accounts Receivable	64.62
Capital Account	28,413.03
	$28,477.65

Upon motion duly made and seconded the Association voted unanimously to accept the above report as read.

Dr. Pearson then called for the report of the Executive Committee, which was read by Dr. Leland F. Carlton, as follows:

REPORT OF THE EXECUTIVE COMMITTEE

To the President and Members of the Florida Medical Association in Session at Ocala, Florida, May 14, 1935:

The Executive Committee held four official committee meetings during the fiscal year and acted in its executive capacity whenever necessary.

On May 2, 1934, your committee held its first official meeting, reappointed Stewart Thompson as business manager of the Association and ap-

*Reinstated.

proved a working budget for the ensuing year.

On June 30, 1934, your committee met in Orlando and recommended some rearrangement of the program for the next annual meeting. Owing to the fact that committee reports are more numerous and a number of the reports quite lengthy, additional time for the Association's committee reports had to be arranged. After considerable discussion your committee recommended that the first general session be held at 4:00 p. m. Monday and that the House of Delegates convene at 8:30 p. m. Monday. This arrangement seemed to meet the approval of special groups, including the Railway Surgeons and Committee on Scientific Work.

The next order of business was the designating of the time and place for the pre-convention meeting. The date decided upon was February and the place Orlando.

On Sunday, October 14, 1934, your committee met in the Marion Hotel at Ocala. Representatives from the Railway Surgeons were present and discussed the time allotted for their annual meeting. Your committee's previous action was accepted by the Railway Surgeons' representatives.

On February 7, 1935, at Orlando, your committee authorized the use of the Coca-Cola advertisement in the Journal, provided all copy be edited by the Secretary of the Association.

At the request of Dr. J. C. Davis, Chairman of the Legislative Committee, the sum of $250.00 was approved for an attorney to draft bills, to do missionary work prior to the convening of the legislature. The sum of $250.00 was also approved for Dr. Davis to secure the services in the legislature of Mrs. Bostwick for daily service during the legislature, copies of bills, etc. In addition to these two amounts your committee approved incidental expenses such as postage, telegrams, etc., which would be over and above the amounts above designated.

At the request of Dr. H. C. Dozier your committee approved the appointment of Dr. J. T. Googe as Liaison Officer for the Florida Medical Association and the FERA.

The following resolution by Dr. J. Ralston Wells was adopted and a copy submitted to our delegates to be presented at a special meeting of the House of Delegates of the American Medical Association:

"*Whereas,* The medical profession of the United States is being slowly but surely pushed into the channels of socialism, by intensive propaganda in favor of socialistic medicine, by those parties who have interested themselves in relegating our honorable profession to such a basis, and

"*Whereas,* such a system has proven most unsatisfactory in other countries to both the physician and the patient; it having destroyed incentive for research work and the further perfection of medical and surgical skill, and

"*Whereas,* we as members of the medical profession of the United States, realize that steps must be taken to offset this propaganda and to enlighten the public of the fallacy of such a system,

"THEREFORE, BE IT RESOLVED: By the Public Relations Committee of the Florida Medical Association, that the American Medical Association be urged to conduct an educational campaign by radio, to inform the public of the dangers and disadvantages of socialistic medicine, and that such a system would not have conquered yellow fever, bubonic plague, cholera, smallpox, typhoid fever, diabetes, diphtheria and many other diseases. That this campaign by radio consist of a national broadcast from coast to coast not less than once a week. That this campaign consist, not of articles or addresses by prominent men, but of a broadcast similar to the 'March of Time,' depicting some of the horrible scenes that have occurred during the epidemics, such as bubonic plague, yellow fever, etc.; a program that will recall to the public mind the debt it owes to organized medicine for having annihilated these scourges; contrasting the enormous amount of research work that is being conducted today with what might happen should we be placed under socialized medicine.

"THEREFORE, BE IT FURTHER RESOLVED: That this resolution be presented to the Executive Committee of the Florida Medical Association for endorsement and that it be given to our delegates with instructions to present same to the next meeting of the House of Delegates of the American Medical Association.

(Signed) J. RALSTON WELLS, Chairman;
J. R. CHAPPELL, Secretary;
H. MASON SMITH,
THOMAS E. BUCKMAN,
H. C. DOZIER,
HUBERT A. BARGE."

Your committee also approved the schedule of rules and regulations presented jointly by the Committee on Medical Economics and the FERA. This code of rules and regulations was published in the Journal, reprints run off, and has been in use since December, 1934.

The following action was taken by the Committee with reference to the report of the Reference Committee of the Special Session of the House of Delegates of the American Medical Association:

"Pursuant to the Special Session House of Delegates of the American Medical Association held in Chicago, February 15 and 16, 1935, the Florida Medical Association concur in the support of the report of the Reference Committee, copy of which is attached.*

"The report of the Reference Committee as approved by the American Medical Association is also approved by the Florida Medical Association as a general plan of procedure. But for the best interest of the patient, the hospital and

*Published in April, 1935, Journal.

the profession in general, it is the desire of this State Association that we disapprove for the State of Florida any proposed form of insurance for the purpose of defraying either hospital or medical expenses.

"Lay control, as provided in the various plans of hospital and medical insurance, especially pertaining to medical management is very objectionable. Experience has shown that it has not proven to the best interest for the welfare of the people in the preservation of health and that it will necessarily retard the advancement of medical science.

"Therefore, it is the consensus of opinion of the Executive Committee of and for the State Medical Association that the Society as a whole do not approve any plan for hospital or medical insurance for the State of Florida."

The following resolution is offered by the committee:

"*Whereas*, on July 14, 1850, at Apalachicola, Florida, there was served for the first time artificial ice, which was made by an ice machine invented by Dr. John Gorrie, of that city, and

"*Whereas*, Dr. Gorrie, for about a quarter of a century was in active practice in this community, and

"*Whereas*, in recognition of his epoch-making invention and his 25 years of diligent service to humanity as a rural doctor, there has been chartered, within the past year, a corporation under the name of Dr. John Gorrie Ice Memorial Foundation, a corporation not for profit, and

"*Whereas*, the objects and aims of this organization are to carry on a national cancer educational compaign among laymen and physicians, and

"*Whereas*, the officers and directors of the Foundation include active members of the Florida Medical Association.

"Be It Resolved: That the Florida Medical Association do endorse the Dr. John Gorrie Ice Memorial Foundation, Incorporated."

Respectfully submitted,
Leland F. Carlton, Chairman;
Leigh F. Robinson,
Frederick J. Waas,
Homer Pearson,
Shaler Richardson.

It was moved and seconded that the above report be adopted as read. Unanimously carried.

In the absence of Dr. T. Z. Cason, Chairman of the Committee on Post-Graduate Work, the following verbal report was made by Dr. George C. Tillman:

REPORT OF COMMITTEE ON MEDICAL POST-GRADUATE COURSE

This report was to have been presented by the chairman of our committee, Dr. Cason, who was unable to attend yesterday. He delegated me to give the report, and as you know I did not get here either. Therefore the report will be rather brief.

No doubt you have seen in the last issue of the Florida Medical Journal a resumé of the work of the post-graduate course. While the attendance is not very great, still we are much encouraged, and the speakers are even more encouraged than we are. They have been in these things before and they think we have the best attendance at our post-graduate courses of any they have ever attended. We think we should have two hundred men this year.

Your committee has gone to considerable work and effort to give you, I think, the best post-graduate course that we have ever had. You will find at the registration desk, a pamphlet on this work, and I would ask that each of you go back and make arrangements to be with us.

Our financial status is not so good. That is the main thing we wish to report today. In the first year we had a slight surplus, that is about $45.00. Our assets amounted to $81.89 in the treasury. Eighty-nine members paid for the course, a total of $445.00, leaving $526.89 in the treasury. Expenses during the last course amounted to $491.89. We have an unpaid bill of $90.00 and only $35.00 in the treasury. Ninety dollars unpaid. Gentlemen, this is rather deplorable. It is rather embarrassing for your committee that anything sponsored by the Florida Medical Association cannot pay for itself. It has been particularly embarrassing for several of us who are responsible for bringing these men down here and then not being able to pay their expenses promptly. We do not feel that it is our duty to pay these things out of our pockets. It was our understanding at the time these courses were started that the Florida Medical Association would underwrite them to the extent of $500.00. There is still an unpaid bill of $90.00 of one year's standing to the embarrassment of the committee. Therefore I recommend that something be done at your House of Delegates today to offset this. Unless something can be done your committee feel that they will be unable to continue in this work.

It was moved, seconded and carried that the above report of this committee be accepted.

The report of the Council was not read before the Association due to the absence of the chairman.

Dr. Leigh Robinson offered a motion that Article VI, Section 2, be amended in the first sentence to read: "The Association shall hold an annual meeting at a place selected by the outgoing Executive Committee."

It being understood that the above motion was to amend the Constitution, it was accepted to be held over until next year.

Dr. Henry Hanson: "I want to take this opportunity to ask the State Association to extend an invitation to the American Public Health Association to meet in Florida in 1936. I hope that this Association will extend this courtesy and that I may be privileged to carry it to Milwaukee and there present it to the governing council. I am a member of the governing council from Florida and I would like to carry this invitation with me.

"The American Public Health Association, as you may know, is growing to the size of being second only to the American Medical Association, and it would be a great help to the Public Health program in Florida, and it would be a great advertisement for the state to have the American Public Health Association here next year. There is practically no expense involved so far as the State Association or any other body is concerned in extending this invitation. It is all our way."

Dr. Hanson then made the motion that the Association extend an invitation to the American Public Health Association to meet in Florida in 1936.

The above motion was seconded and unanimously carried.

Dr. Pearson announced that the unpaid bill of $90.00 referred to in the report of the committee on post-graduate work had not been paid by the Association for the reason that it had not been presented to the business office nor to the Executive Committee for consideration.

Dr. J. C. Davis, Chairman of the Legislative Committee, offered as a motion that the following telegram be sent by the Association to Senators: Sweger, Mann, Turner, Touchton and Rose, also Representatives: Rogers, Hubbell, Warren and Hazen: "The Florida Medical Association now in session desire to express their appreciation of the consideration and favorable support you have given the bills proposed by us."

The above motion was duly seconded and carried, and Dr. Pearson ordered the telegrams sent.

Dr. Homer L. Pearson of Miami read his Presidential Address, entitled, "The Physician and His Government."

The Guest Speaker, Dr. James E. Paullin of Atlanta, Ga., Professor of Clinical Medicine at Emory University, and President of the Georgia Medical Society, was introduced by Dr. Pearson. Dr. Paullin delivered an oral address on "Arthritis," with lantern slides.

Dr. Pearson then presented Dr. H. Marshall Taylor of Jacksonville, a Past President of this Association, and now President of the Southern Medical Association.

Dr. Taylor expressed his appreciation but stated that he felt the honor was due the Florida Medical Association rather than himself.

Adjournment of the second general session.

SECOND SCIENTIFIC ASSEMBLY

The Scientific Assembly reconvened at 2:00 p. m., May 14th, with Dr. Louie M. Limbaugh presiding.

The following papers were read and discussed:

4. "Florida Sores—A Misnomer," Dr. Chadbourne A. Andrews, Tampa.
5. "The Care of Cataract Patients," Dr. Shaler Richardson, Jacksonville.
6. "The Tonsil Problem," Dr. L. C. Ingram, Orlando.
7. "Observations on the Mechanism and Treatment of Circulatory Failure" (lantern slides), Dr. E. W. Bitzer, Tampa.

SECOND MEETING OF THE HOUSE OF DELEGATES

The second meeting of the House of Delegates convened at 5:00 p. m., Tuesday, May 14th, in the Dixie Theatre.

Roll Call.

Due to an error in ruling the resolution read by Dr. H. A. Day at the last meeting of the House of Delegates was stated to be an amendment to the constitution, but in reality was a proposed amendment to the By-Laws. On motion by Dr. Day, seconded by Dr. Christ, the President ruled that this resolution had been read at the previous meeting and was therefore open to consideration by the House.

Dr. Day then re-read his resolution.

It was requested that the resolution be amended to include Monroe County within the southeastern district. Dr. Alsobrook offered this as a motion, and the amendment was accepted by Dr. Day.

Dr. Day's resolution together with Dr. Alsobrook's amendment was then voted and unanimously adopted, as follows:

CHAPTER VII.—BY-LAWS

SECTION 1. Regular committees shall be the Executive Committee (or may be called the Board of Governors); A Committee on Scientific Work; A Committee on Legislation and Public Policy; A Committee on Publication; A Committee on Medical Education and Hospitals; A Committee on Public Relations. They shall be appointed by the President as hereinafter prescribed. The Committee on Arrangements shall consist of the component society where the Annual session is to be held.

The Florida Medical Association shall be divided into six committee districts as follows: Northwest, North Central, Northeast, Southwest, South Central and Southeast districts. The *Northwest District* (A) to include the following counties: Escambia, Santa Rosa, Okaloosa, Walton, Holmes, Washington, Bay, Jackson, Calhoun, Gulf, Gadsden, Liberty, Franklin, Leon, Wakulla, and Jefferson. The *North Central District* (B) to include Madison, Taylor, Hamilton, Suwannee, Lafayette, Dixie, Columbia, Gilchrist, Levy, Baker, Union, Bradford, Alachua, Marion, Citrus, Sumter, Hernando, and Pasco Counties. The *Northeast District* (C) to include Nassau, Duval, Clay, St. Johns, Putnam, Flagler, and Volusia Counties. The *Southwest District* (D) to include Hillsboro, Pinellas, Manatee, Sarasota, Polk, Hardee, DeSoto, Charlotte, Lee, Highlands, Glades, Hendry, and Collier Counties. The *South Central District* (E) to include Lake, Orange, Seminole, Osceola, Brevard, Indian River, Okeechobee, St. Lucie, and Martin Counties. The *Southeast District* (F) to include Palm Beach, Broward, Dade and Monroe Counties.

SECTION 2. The Executive Committee (or Board of Governors) shall consist of the President and Secretary, *ex-officio*, and six members, one from each district, to be appointed by the President. Upon the adoption of this amendment to the By-Laws, the President shall appoint six members as designated above, two for one year, two for two years, and two for three years, and thereafter they shall be appointed for three years as the terms expire. This committee shall meet immediately after the adjournment of the annual session and elect their Chairman. It shall consider and act upon all matters of business pertaining to the Association in the interval between the annual meetings, and shall render a report of its actions to the second general session.

SECTION 3. The Committee on Scientific Work shall consist of six members, one from each district, to be appointed by the President. Upon the adoption of this amendment, the President shall appoint six members as designated above, two for one year, two for two years, and two for three years and thereafter they shall be appointed for three years as the terms expire. This committee shall meet immediately after the adjournment of the annual session and elect its Chairman. It shall determine the character and scope of the scientific proceedings of the Association, subject to the provisions in the Constitution and By-Laws. It shall prepare and issue a program for each annual meeting, announcing the order in which papers, discussions, and other business shall be presented. The number of papers to be read before each annual meeting shall be left to the discretion of the Committee on Scientific Work, but no member shall be permitted to present a paper in successive years.

SECTION 4. The Committee on Legislation and Public Policy shall consist of the President and Secretary, *ex-officio*, and six members, one from each district, to be appointed by the President. Upon the adoption of this amendment, the President shall appoint six members as designated above, two for one year, two for two years, and two for three years and thereafter, they shall be appointed for three years as the terms expire. Under the direction of the House of Delegates, it shall represent the Association in securing and enforcing legislation in the interest of the public health and scientific medicine. It shall keep in touch with professional and public opinion, shall endeavor to shape legislation so as to secure the best results for the whole people, and shall use every organized influence of the profession to promote the general influence in local, state, and national affairs and election. Its work shall be done with the dignity becoming a great profession, and with that wisdom which will make effective its powers and influence. It shall have the authority to be heard before the entire Association upon questions of great concern at such time as may be arranged during the annual meeting.

Dr. George Dame moved that the House of Delegates reconsider the vote to select a meeting place for the 1936 meeting. Seconded and lost.

Dr. T. Z. Cason, Chairman of the Committee on Post-Graduate work, was recognized.

"I want to bring out two things with reference to the post-graduate courses at Gainesville. We want you to appropriate, not guarantee, but appropriate $500.00 for this committee's use, to be used as a revolving fund.

"Dr. Tillman gave you a report and you know the situation we are in. I want to make it perfectly clear that no one is to blame for this situation. We did the best we could. It is not Dr. Richardson's fault. It is not Dr. Thompson's fault. Nobody is to blame.

"The past three years have been largely experimental. I have been a member of the committee since its incipiency, and I can say without ego that we have done a good job. The course presented this year cannot be surpassed and is not surpassed as a post-graduate course anywhere in the United States.

"As I have said, nobody is to blame for this situation. However, it has been very embarrassing to the committee. Now, you can remedy that situation. I pledge you my word of honor, which is all that I can, that if you appropriate this $500.00, I will get the committee organized, draw up definite rules of government, appoint a treasurer, have the books audited and send the auditor's report to the State Association. They will not be responsible, only the committee will be responsible.

"We need this money in advance. As you may know Dr. Tillman has already paid some bills personally. I recall one instance during the first year, when a man from Chicago who was on the program left the city hurriedly and reached Gainesville only to find himself without funds. He came and asked me what he could do about it. We had no funds from which to draw and Dr. Tillman paid him out of his own pocket. We need the proper setting. Otherwise it is

embarrassing. And we think we deserve it. If you do not have that much faith in us, or if you feel that we have not done anything to warrant it, then dismiss the committee and discontinue the work. We know that it can be done, and we believe that it is the only proper way to handle it. Dr. Richardson and Dr. Thompson have agreed to that. There is no argument.

"There is one more thing: I am informed by the outgoing president that I will be chairman for another year. I will be glad to serve, but it is up to you.

"I knew nothing about the resolution Dr. Day has presented as an amendment to the By-Laws, but it is something that we have been going over for the past several months with reference to this committee. We do want certain changes made in this committee.

"We want one man to be a permanent member of the committee, to represent the University. Dr. Tillman would be that man now. If Dr. Tillman resigns as University physician, then the man appointed to take his place at the University would then represent the University on the committee provided he is a qualified member of the Florida Medical Association. In addition to this we want three current members, one appointed for one year, one for two years and one for three years. But at the end of that time the men appointed will be for two and three years. The idea is exactly the same as brought out this morning. It is our idea that three men should not come off the committee at any one time.

"Another thing: The committee should not in any wise adopt a political policy as that is apt to cause serious complications.

"We would like to have the committee arranged so that one man will come off each year and always two men holding over aside from the representative of the University. In that way we feel that your post-graduate course will continue as long as you want it, or that it proves worth while for the state.

"I want to say that I am glad to stay on next year. I feel that with help your committee will be able to put the post-graduate course on such a basis that it will automatically take care of itself and carry on. It is not yet properly organized to automatically carry on by itself, and your committee feels that without these two things it could not be done.

"I thank you."

Motion by Dr. Christ that the $500.00 requested as a revolving fund be turned over to Dr. Cason. Seconded and unanimously adopted.

Dr. M. A. Lischkoff, representing the Escambia County Medical Society, presented for life membership in this Association the name of Dr. J. H. Pierpont of Pensacola. Dr. Pierpont has been elected President of the Florida Medical Association on three occasions, in 1890, in 1901 and again in 1902.

Dr. Lischkoff also presented for life membership the name of Dr. F. D. Renshaw, who has been an active worker in the Association for forty years.

It was voted and unanimously carried that Dr. J. H. Pierpont and Dr. F. D. Renshaw be elected to life membership.

Dr. Pearson then called attention to the fact that the time Dr. Pierpont was first elected President of the Florida Medical Association forty-five years ago, the annual meeting was being held, as at the present time, in Ocala.

A telegram was then read by the President from Dr. J. C. Davis, chairman of the Legislative Committee, urging cooperation and support in an effort to defeat Senate Bill No. 377, unfavorable to the Medical Association.

The following resolution was submitted by Dr. George Dame:

"Resolved: That the Florida Medical Association defray the transportation expenses of its delegates to the annual convention of the American Medical Association."

The above resolution was voted and carried.

On motion by Dr. Peek, unanimously carried, the following telegram was ordered sent to Dr. J. C. Davis, of the Legislative Committee:

"The House of Delegates in annual session at Ocala voted unanimously to oppose Senate Bill No. 377. Any help we can be to you, please command us.

(Signed) Homer L. Pearson, President."

Dr. Boulware requested that the privileges of the floor be accorded Mr. Cornell. Motion denied.

Dr. Eugene Peek called the attention of the Association to the serious illness of one of its members, Dr. Ralph N. Greene of Jacksonville. He then offered a motion that the House of Delegates wire Dr. Greene expressing their regret that he is unable to attend the meeting.

Dr. Cason seconded Dr. Peek's motion, stating that Dr. Greene had sent his greetings to the

Association by him, and regretted his inability to be present.

Voted unanimously, and the following telegram ordered sent to Dr. Greene:

"The House of Delegates of the Florida Medical Association in annual session at Ocala expresses deep regret that you were unable to meet with us this year. We sincerely hope you will have a speedy and complete recovery and will be able to meet with us next year.

(Signed) Homer L. Pearson, President."

Dr. Pearson: "It has been an extreme pleasure to work with you, and I appreciate a great deal your cooperation and good will."

Meeting adjourned.

THIRD SCIENTIFIC ASSEMBLY

The Third Scientific Assembly was held Wednesday, May 15th, 9:00 a. m., Dr. G. S. Osmcup presiding. The following papers were read and discussed:

8. "Boils and Carbuncles," Dr. J. R. Chappell. Orlando.
9. "Principles of Plastic Surgery of Benefit to the General Surgeon" (lantern slides). Dr. Thomas O. Otto, Miami.
10. "Infections and Treatment of Cervix Uteri," Dr. W. C. Payne, Pensacola.
11. "Immunization Against Contagious Diseases of Childhood" (lantern slides), Dr. Warren Quillian. Coral Gables.

THIRD GENERAL SESSION

The General Assembly of the Florida Medical Association reconvened at 12:00 noon, May 15th, in the Dixie Theatre with Dr. Homer L. Pearson, President, in the Chair.

The meeting was called to order, and Dr. Pearson immediately requested Dr. J. N. Moore to announce the results of the golf tournament and present the prizes.

The Orlando Cup, first prize for low net score, was presented to Dr. M. A. Lischkoff of Pensacola. Dr. Lischkoff was the first doctor to win this loving cup at the time of its presentation by the Orange County Medical Society.

The runner-up or second prize for low net score, a physician's leather bag donated by Mr. Henry Parramore. President of the Surgical Supply Company, was won by Dr. J. Knox Simpson of Jacksonville.

The third prize, a dozen golf balls, donated by the Marion County Medical Society, was presented for distribution to Dr. Warren Quillian, one of four doctors whose scores tied for this prize.

Dr. Pearson read a telegram from Dr. J. C. Davis of the Legislative Committee stating that their bills would be on tomorrow's calendar, also Bill No. 831, which they desired opposed and asking that telegrams be sent to the Representatives. Dr. Pearson requested all members to wire their Representatives to support their bills and urging them to oppose Bill No. 831.

There being no unfinished or new business, the meeting proceeded to the election of officers for the ensuing year.

Dr. O. O. Feaster of St. Petersburg was nominated for President-elect by Dr. J. W. Alsobrook, seconded by Dr. L. M. Anderson. Dr. W. H. Spiers moved that the nominations be closed and the Secretary instructed to cast a unanimous ballot for Dr. Feaster. Motion seconded and carried.

Dr. Pearson declared Dr. Feaster elected and requested him to address the Assembly.

Dr. Feaster: "Naturally I am indeed grateful for your conferring upon me the highest honor at your command in this Association. I shall strive in every way possible to do everything that I can for the protection and advancement of organized medicine in these strenuous times.

"I bespeak for Dr. Pearson's successor your loyalty and help, and when the time comes that I succeed him to the Chair I am sure that I will have that same loyalty.

"My one hope is that I may be able to be even one-half as good a President as Dr. Homer Pearson has been this past year.

"I thank you."

Dr. Eugene Peek of Ocala was nominated for the office of First Vice-President by Dr. L. M. Anderson, who also moved that the nominations be closed and the Secretary be instructed to cast a unanimous ballot for Dr. Peek. Motion seconded by Dr. Alsobrook and unanimously carried.

Dr. Alsobrook then nominated Dr. W. H. Spiers of Orlando as Second Vice-President.

Dr. Spiers requested that his name be withdrawn, and that Dr. Alsobrook be nominated for this office. Withdrawal denied.

Doctors Strickland and Chappell were appointed tellers. A ballot vote resulted in the election of Dr. Alsobrook.

Dr. F. J. Waas then nominated Dr. J. S. Turberville of Century for Third Vice-President.

Dr. Alsobrook nominated Dr. Gerard Raap of Miami for Third Vice-President.

Nominations were closed and Drs. Winchester and Leigh Robinson appointed tellers. A ballot vote resulted in the election of Dr. Turberville.

Dr. L. M. Anderson offered the nomination of Dr. Shaler Richardson for Secretary-Treasurer, and moved that the President close the nominations and cast a unanimous ballot for Dr. Richardson. Motion seconded and carried and vote cast by Dr. Pearson.

Dr. Alsobrook made a motion that the Association arise and give a rousing vote of thanks to the Marion County Medical Society for the numerous courtesies extended during this convention.

Rising vote of thanks to the Marion County Medical Society.

Dr. Pearson: "I am sure the members of this Association have been imposed upon enough by speeches from retiring Presidents. However, it becomes my painful duty to inform you that I will shortly become a past President of this Association. Rather than make a speech I will only state that I want to thank all members of this Association for their hearty cooperation during the past year, and especially the secretaries and chairmen of the committees who have been so loyal in their support and so wholehearted in their work for the Association during the past year. I can only hope that your incoming President will have as much cooperation and support as you have given me.

"It cannot help but make me feel good to know that the Florida Medical Association members have been almost one hundred per cent in their efforts to do the things that your committees and officers have asked them to do. I want to thank you from the bottom of my heart for all of the good things and all of the excellent words that have passed on about me.

"At this time I will just take a deep bow and ask that Dr. Bryans be escorted to the Chair."

Dr. Eugene Peek of Ocala then asked permission to address the Association in behalf of the Marion County Medical Society. Dr. Peek expressed the appreciation of the Marion County Medical Society for the meeting being held in Ocala, and stated that they were especially grateful for the large percentage of attendance, the third largest attendance made by the Florida Medical Association. And he hoped that the visiting members had enjoyed the convention as much as the local members. He expressed the hope also that the convention might again be held in Ocala within the next few years.

Dr. Pearson: "At this time it is my pleasure to introduce to you Dr. Herbert L. Bryans, President."

Dr. Bryans: "In taking over the high office which you have conferred upon me, I assure you that the duties associated therewith are entered upon with a keen appreciation of the responsibility which you have vested in me. I greatly appreciate the honor.

"Thanks to our retiring President, I have been privileged to attend various committee meetings during the past year and thus acquire familiarity with current phases of their activities.

"The committees for the coming year have been selected after consultation with a most competent group of advisors and each appointee is fully aware of the duties he is assuming and has unlimited confidence and support.

"Organized medicine is striving to solve economic problems of adapting medical care to a rapidly changing general economic and social environment, and still retain the essential control in the field of service. To this end the medical and allied professions must stand united on problems pertaining to the care of the sick.

"The relationship of physician and patient cannot be greatly altered without destroying the whole framework of medical practice which local, state and national medical societies have developed.

"I wou'd appreciate suggestions from every one of you. It is not my desire to put forward personal ideas but rather to represent the ideas of the majority.

"In conclusion, I pledge the Florida Medical Association my very best and may I ask your full cooperation at all times?"

At the request of the President, Dr. L. M. Anderson presented the Past President's emblem to Dr. Homer L. Pearson.

Dr. Anderson: "Dr. Pearson: It affords me a great deal of pleasure to pin this emblem on you. You have been our President for one year. You have worked hard, worked conscientiously. I know some of the hardships you have faced, and I think every member of this Association appreciates your work. I now pin this emblem on you. It is a beautiful emblem. I would like to digress

one moment here and urge the rest of you Past Presidents to wear your emblems. Why don't you wear them? You should be proud to wear them. I wear mine every year and appreciate it very much. It has been the custom of this Association every year since I have been a member to pin one of these emblems on the retiring President, and I, myself, have done this for a number of years. It now affords me an exceptional pleasure to present this emblem to the youngest man ever to be President of the Association and the one who has done the hardest work."

Dr. Pearson: "I thank you."

Dr. Bryans appointed members of the Executive Committee: Drs. Jelks (3 years), Palmer (3 years), Osincup (2 years), Holmes (2 years), Bates (1 year), and Gilmer (1 year), and as members of the Committee on Scientific Work: Drs. Robinson (3 years), Webb (3 years), T. M. Palmer (2 years), Chappell (2 years), Pate (1 year), George Dame (1 year), committees to meet immediately following this session.

There being no further business, the meeting adjourned, *sine die*.

REGISTRATION

The total registration during the Sixty-second Annual Meeting of the Florida Medical Association, held in Ocala, May 13, 14, and 15, was 472; members, 311; visitors, 27; exhibitors, 22; Woman's Auxiliary, 112.

Officers

PEARSON, HOMER L., President.....Miami
BRYANS, HERBERT L., President-elect.....Pensacola
McIVER, ROBERT B., First Vice-President....Jacksonville
FEASTER, ORION O., Second Vice-President..St. Petersburg
FERGUSON, ROBERT D., Third Vice-President.....Ocala
RICHARDSON, SHALER, Secretary-Treasurer...Jacksonville
THOMPSON, STEWART, Business Manager....Jacksonville

Alachua County Medical Society

Anderson, James M. Cross City
Cobb, Alva T. Raiford
Dailey, I. A. Micanopy
Dell, J. Maxey.....Gainesville
Dell, J. Maxey, Jr. Gainesville
Hodges, James H. Gainesville
Maines, John E., Jr. Gainesville
Maines, John E., Sr. Lake Butler
Smith, DeWitt T. Gainesville
Summerlin, J. L. Gainesville
Tillman, George C. Gainesville
Willis, J. M. Williston

Brevard County Medical Society

Bean, I. F. Melbourne
Page, Walter C. Cocoa

Broward County Medical Society

Butler, Bruce F. Hollywood
Connor, A. B. Ft. Lauderdale
Hendricks, Elliott M. Ft. Lauderdale
McClellan, George S. Pompano
Peavy, Henry J. Ft. Lauderdale
Robinson, Leigh F. Ft. Lauderdale

Columbia County Medical Society

Anderson, L. M. Lake City
Bates, T. H. Lake City
Ives, W. M. Lake City

Dade County Medical Society

Barge, H. A. Miami
Burch, R. N. Miami
Cleghorn, Charles D. Miami
Dunaway, Carl E. Miami
Freeman, Mary Perrine
Gowdy, Francis A. Miami
Hall, E. J. Miami
Hall, John E. Miami
Hobbs, Laura Mae.....Miami
Hodsdon, Benjamin F. Miami
Jones, Allan Miami Beach
Jones, Walter C., Jr. Miami
Kinsey, E. T. Miami
Lucinian, J. H. Miami
McKibben, W. W. Miami
Otto, T. O. Miami
Owens, Duncan Miami Beach
Panettiere, Cayetano Miami Beach
Payton, Frazier J. Miami Beach
Perdue, John R. Miami
Quillian, Warren Coral Gables
Raap, Gerard Miami
Repass, Robert E. Miami Beach
Sams, Wiley M. Miami
Snyder, John W. Miami
Stewart, J. S. Miami
Tumlin, C. E. Miami
Walker, Harrison A. Miami Beach
Youmans, I. C. Miami

DeSoto-Hardee-Highlands County Medical Society

Martin, L. W. Sebring
Peacock, W. H. Wauchula
Weems, H. V. Sebring

Duval County Medical Society

Black, J. B. Jacksonville
Boone, James L. Jacksonville
Brink, Fritz A. Jacksonville
Brown, Alan DeWitt.....Jacksonville
Buckman, Thomas E. Jacksonville
Cason, Turner Z. Jacksonville
Copeland, Silas M. Jacksonville
Driskell, Simon E. Jacksonville
Dyrenforth, Lucien Y. Jacksonville
Eaton, Paul Jacksonville
Erwin, Stanley Jacksonville
Field, Thomas S. Jacksonville
Hanson, Henry Jacksonville
Holden, Gerry R. Jacksonville
Holloway, Luther W. Jacksonville
Ira, Gordon H. Jacksonville
Jelks, Edward Jacksonville
Kirby-Smith, J. Lee.....Jacksonville
Limbaugh, Louie M. Jacksonville
Lipscomb, T. H. Jacksonville
Lverly, J. G. Jacksonville
Mabry, C. B. Jacksonville
Manning, W. S. Jacksonville
Norris, S. R. Jacksonville
Pasco, J. D. Jacksonville
Richards, Ferdinand Jacksonville
Ross, William E. Jacksonville
Sellers, E. T. Jacksonville
Shaw, W. M. Jacksonville
Simpson, J. Knox.....Jacksonville
Swift, Edwin C. Jacksonville
Taylor, H. Marshall.....Jacksonville
Teeter, E. H. Jacksonville
Upchurch, N. A. Jacksonville
Van Schaick, H. D. Jacksonville
Waas, Frederick J. Jacksonville
Washburn, Clayton D. Jacksonville
Wilson, A. K. Jacksonville
Woolsey, B. F. Jacksonville

Escambia County Medical Society

Hoffman, James M. Pensacola
Kennedy, S. G. Pensacola

Lischkoff, M. A. Pensacola
McLane, J. N. Pensacola
Payne, W. C. Pensacola
Turberville, J. I. Century
Turberville, J. S. Century
White, Alvyn W. Pensacola

Hillsboro County Medical Society

Allen, Bundy Tampa
Alsobrook, J. W. Plant City
Andrews, C. A. Tampa
Beyer A. R. Tampa
Bidwell, A. M. Tampa
Bitzer, E. W. Tampa
Blackmon, H. J. Tampa
Blake, W. C. Tampa
Boling, John R. Tampa
Bottari, G. C. Tampa
Brown, G. W., Jr. Tampa
Brown, H. O. Tampa
Carlton, Leland F. Tampa
Cook, H. M. Tampa
Cowart, J. T. Tampa
Dickinson, J. C. Tampa
Draper, A. D. Tampa
Duke, R. R. Tampa
Duncan, W. P. Tampa
Ely, R. A. Tampa
Estes, J. L. Tampa
Etheredge, S. H. Tampa
Garcia, Parsons M. West Tampa
Gilbert, Elsie Tampa
Gilmer, E. S. Tampa
Grable, James S. Tampa
Gyland, Stephen P. Tampa
Hardy, G. E. W. Tampa
Helms, John S., Jr. Tampa
Henderson, R. P. Tampa
Holloway, E. W. Tampa
Jobson, A. M. C. Tampa
Knauf, A. R. Tampa
Knight, J. C. Plant City
Lowry, B. W. Tampa
Metzger, Frank C. Tampa
Mills, Herbert R. Tampa
Moore, John T. Tampa
Nelson, Robert G. Tampa
Pate, J. C. Tampa
Pease, Charles W. Tampa
Saxton, J. J. Tampa
Shaver, E. F. Tampa
Smith, H. Mason Tampa
Smoak, Edward Tampa
Spoto, Joseph S. Tampa
Taylor, J. W. Tampa
Torbett, R. S. Tampa
Torretta, Joseph N. Tampa
Vinson, J. C. Tampa

Jackson County Medical Society

Box, C. C. Graceville
McKinnon, D. A. Marianna

Lake County Medical Society

Ashton, W. Lee Umatilla
Bowen, Louis R. Eustis
Coleman, E. M. Groveland
Colley, Sanford C. Tavares
DeVane, W. G. Groveland
Hannum, M. M. Eustis
Holland. Howard G. Leesburg
Oetjen, Leroy H. Leesburg
Williams, Rabun H. Eustis

Lee County Medical Society

Bostelman, Ernest Ft. Myers
Jones, H. Quillian Ft. Myers

Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society

Davis, Julius C. Quincy
Dozier, L. L. Tallahassee
Jenkins, O. W. Chattahoochee
McClure, Herbert A. Tallahassee
Moor, F. Clifton Tallahassee
Palmer, Henry E. Tallahassee
Pound, J. H. Chattahoochee
Robertson, J. C. Chattahoochee
Salley, S. Marion Tallahassee
Wilhoit, Sterling E. Quincy
Wilkinson, B. A. Tallahassee

Manatee County Medical Society

Gates, Hubbard Bradenton
McDuffee, T. M. Manatee

Marion County Medical Society

Chalker, James L. Ocala
Cumming, Richard C. Ocala
Dozier, Henry C. Ocala
Freeman, Albert H. Ocala
Gatrell, Henry Fairfield
Hood, J. W. Ocala
Lindner, E. G. Ocala
Lisk, Percy F. Ft. McCoy
Lytle, Carl S. Dunnellon
Martin, Irl E. Ocklawaha
Moore, J. N. Ocala
Peek, Eugene G. Ocala
Russell, Ralph E. Ocala
Slaughter, T. K. Wildwood
Strange, J. L. McIntosh
Wallis, Thomas H. Ocala
Watt, H. F. Ocala

Orange County Medical Society

Andrews, M. M. Orlando
Beardall, Harold M. Orlando
Brinson, Haynes Kissimmee
Calvert, Read N. Orlando
Chappell, John R. Orlando
Christ, Calvin D. Orlando
Collins, Charles J. Orlando
Day, Horace A. Orlando
Hart, Ruth S. Winter Park
Ingram, L. C. Orlando
Lynn, C. W. Orlando
McEwan, Duncan T. Orlando
McEwan, John S. Orlando
Mallory, Meredith Orlando
Neal, Thomas A. Orlando
Orr, L. M. Orlando
Osincup, Gilbert S. Orlando
Page, W. Grady Orlando
Pines, John A. Orlando
Ricker, Samuel F. Orlando
Rivers, T. M. Kissimmee
Shoemaker, Samuel A. Orlando
Sinclair, W. E. Orlando
Spiers, William H. Orlando
Sutter, Leroy M. Orlando
Weed, Walter A. Orlando

Palm Beach County Medical Society

Buck, William J. Belle Glade
Dawson, George M. W. Palm Beach
Herpel, Frederick K. W. Palm Beach
Johnson, Vesey M. W. Palm Beach
Netto, Lloyd J. W. Palm Beach
Rozier, L. M. W. Palm Beach
Savad, William Y. W. Palm Beach
Schiffli, O. F. Clewiston
Shackelford, C. W. W. Palm Beach
Shackelford, W. L. W. Palm Beach
Van Landingham, W. E. W. Palm Beach

Pasco-Hernando-Citrus County Medical Society

Creekmore, George R. Brooksville
Dame, George A. Inverness
Dame, Leland H. Inverness
Harvard, S. C. Brooksville
Hudson, P. J. Crystal River
Jones, W. Wardlaw Dade City
Moon, William B. Crystal River

Pinellas County Medical Society

Davis, W. M. St. Petersburg
Gable, N. W. St. Petersburg

Herring, John A. St. Petersburg
Knowlton, R. H. St. Petersburg
McConnell, W. C. St. Petersburg
Mease, J. A., Jr. Dunedin
Mills, Alvin L. St. Petersburg
Owen, W. S. St. Petersburg
Roush, Franklin W. St. Petersburg
Rudolph, C. C. St. Petersburg
Simcox, Lawrence St. Petersburg
Stevens, R. E. St. Petersburg
Strickland, J. A. St. Petersburg
Winchester, H. E. Dunedin
Wood, A. J. St. Petersburg

Polk County Medical Society

Bird, D. Paul Lakeland
Bond, Benjamin J. Winter Haven
Boulware, James Lakeland
Clark, S. A. Lakeland
Cline, R. L. Lakeland
Gilbert, R. E. Winter Haven
Hargrove, Julian L. Bartow
Hurlburt, C. J. Bartow
Lancaster, L. L. Bartow
McMurray, James W. Bartow
Overstreet, G. C. Lakeland
Pennington, B. Y. Lake Wales
Ragsdale, V. H. Pierce
Sullivan, R. R. Lakeland
Tillis, W. L. Lakeland
Watson, Herman Lakeland
Wilson, John F., Jr. Lakeland

Putnam County Medical Society

Ford, E. W. Crescent City

St. Johns County Medical Society

Britt, Reddin St. Augustine
Grace, Charles E. St. Augustine
Lockwood, Vernon A. St. Augustine
Potter, G. W. St. Augustine
Walkup, A. Clark St. Augustine
White, Herbert E. St. Augustine

St. Lucie-Okeechobee-Indian River-Martin County Medical Society

Clark, H. D. Ft. Pierce
Hardee, E. B. Vero Beach
Whiddon, L. L. Ft. Pierce

Sarasota County Medical Society

Halton, Joseph Sarasota
Patterson, J. C. Sarasota
Pinkham, E. W. Sarasota

Seminole County Medical Society

Denton, J. T. Sanford
Smith, H. D. Sanford
Tolar, J. N. Sanford

Sumter County Medical Society

Mitchell, W. E. Bushnell
Wood, S. C. Leesburg

Volusia County Medical Society

Bouchelle, L. B. New Smyrna
Brown, L. V. L. DeLand
Chowning, W. C. New Smyrna
Davis, George A. DeLand
Green, George M. Daytona Beach
Hahn, Theodore F. DeLand
Henry, H. W. New Smyrna
Myres, M. J. Daytona Beach
Pay, W. C. DeLand
Rawlings, J. E. Daytona Beach
Tribble, C. E. DeLand
Wells, J. Ralston Daytona Beach
West, Hugh DeLand
Wood, Evans B. Daytona Beach

Walton-Okaloosa County Medical Society

McDonald, C. W. DeFuniak Springs

Guest of Honor

Paullin, James E. Atlanta, Ga.

Visitors

Ball, H. L. Pensacola
Branan, J. H. Pensacola
Brantley, Z. Grandin
Brewster, W. A. Callahan
Clement, R. M. Chattahoochee
Cleveland, C. P. Jacksonville
Freeman, H. S. Miami
Geddes, J. C. Ocala
Goldsmith, Wm. S. Atlanta, Ga.
Goode, J. A. Alachua
Googe, J. T. Jacksonville
Griffitts, T. H. D. Jacksonville
Hanson, E. C. Belleview
Hilborn, Caroline Battle Creek, Mich.
Hilborn, R. R. Battle Creek, Mich.
Hughlett, W. S. Cocoa
Kappler, George J. W. Palm Beach
Lancaster, W. J. Wilmington, N. C.
Meitin, Ruth Tampa
Morgan, Thomas E. Jacksonville
Neal, C. A. Nicholasville, Ky.
Norman, Estella G. Miami
Preston, H. F. Melrose
Weeks, J. L. Perry
Williams, W. J. Seville
Wilson, J. Frank Jacksonville

Exhibitors

Anderson, T. Emmett Tampa
Avery, W. E. Atlanta, Ga.
Bennett, Joe Jacksonville
Campbell, A. H. Jacksonville
Cuthbert, Guy Tampa
Fassett, L. W. Miami
Heether, H. B. Miami
Jean, O. H. Eau Gallie
Jones, George I. Louisville, Ky.
Jones, Mrs. George I. Louisville, Ky.
Lindley, J. E. Tampa
Mackel, S. C. Tampa
Mills, C. F. Tampa
Nichelson, H. B. Miami
Parramore, Henry L. Jacksonville
Peters, Don A. Jacksonville
Pool, Ralph Columbia, S. C.
Rader, E. E. Atlanta, Ga.
Spitze, Harold Atlanta, Ga.
Thompson, Ray Jacksonville
Troxler, L. B. New York, N. Y.
Weaver, M. H. Jacksonville

WOMAN'S AUXILIARY
MEMBERS AND GUESTS REGISTERED AT THE OCALA MEETING

Miss Eve Ancell New Smyrna
Mrs. C. W. Bache Cocoa
Mrs. Gray Bannester
Mrs. I. F. Bean Melbourne
Mrs. M. F. Beaty Miami Beach
Miss Lenore Baetner, R.N. Umatilla
Mrs. Ernest Bostelman Fort Myers
Mrs. James R. Boulware, Jr. Lakeland
Mrs. Z. Brantley Grandin
Mrs. Haynes Brinson Kissimmee
Mrs. Reddin Britt St. Augustine
Mrs. A. G. Brown Dunnellon
Mrs. L. Van Leer Brown DeLand
Mrs. L. F. Carlton Tampa
Miss Margaret Chalker Ocala
Miss Dorothy Chalker Ocala
Mrs. C. D. Christ Orlando
Mrs. Ralph M. Clements Chattahoochee
Mrs. R. L. Cline Lakeland
Mrs. S. M. Copeland Jacksonville

Mrs. E. F. Cook....Tampa
Mrs. G. R. Creekmore....Brooksville
Mrs. W. M. Cumming....Ocala
Mrs. S. Marion Salley....Tallahassee
Mrs. J. C. Davis....Quincy
Mrs. George M. Dawson....W. Palm Beach
Mrs. J. F. Denton....Sanford
Mrs. H. C. Dozier....Ocala
Mrs. Lucien I. Dyrenforth....Jacksonville
Miss Annie Efta....Umatilla
Mrs. O. O. Feaster....St. Petersburg
Mrs. R. D. Ferguson....Ocala
Mrs. A. H. Freeman....Ocala
Mrs. H. Gates....Bradenton
Mrs. R. E. Gilbert....Winter Haven
Mrs. James Gordon....
Mrs. Stephen Gyland....Tampa
Mrs. T. F. Hahn....DeLand
Mrs. E. C. Hanson....Belleview
Mrs. E. B. Hardee....Vero Beach
Mrs. W. W. Harden....St. Petersburg
Mrs. Herrman Harris....Jacksonville
Mrs. S. C. Harvard....Brooksville
Mrs. G. W. Henry....New Smyrna
Mrs. F. K. Herpel....W. Palm Beach
Mrs. J. M. Hoffman....Pensacola
Mrs. Walter Hood....Ocala
Mrs. L. C. Ingram....Orlando
Mrs. Gordon Ira....Jacksonville
Mrs. Oliver W. Jenkins....St. Petersburg
Mrs. Edward Jelks....Jacksonville
Mrs. A. M. C. Jobson....Tampa
Mrs. L. L. Lancaster....Bartow
Mrs. W. Lassiter....Gainesville
Mrs. E. G. Linder....Ocala
Mrs. V. A. Lockwood....St. Augustine
Mrs. Irl E. Martin....Ocklawaha
Mrs. R. H. Martin....Inverness
Mrs. J. N. Moore....Ocala
Mrs. G. S. McClellan....Pompano
Mrs. W. C. McConnell....St. Petersburg
Mrs. J. W. McMurray....Bartow
Mrs. T. M. McDuffee....Manatee
Mrs. E. R. McMurray....Bartow
Miss Helen McMurray....Bartow
Mrs. M. J. Myres....Daytona Beach
Mrs. Leroy H. Oetjen....Leesburg
Mrs. G. C. Overstreet....Lakeland
Mrs. Duncan Owens....Miami
Mrs. W. C. Page....Cocoa
Mrs. J. C. Patterson....Sarasota
Miss Evelyn Payne Peacock....Wauchula
Miss Edith Ponder....Century
Mrs. G. W. Potter....St. Augustine
Mrs. V. H. Ragsdale....Pierce
Mrs. R. E. Repess....Miami
Mrs. Ferdinand Richards....Jacksonville
Mrs. B. F. Ricker....Orlando
Mrs. Leigh F. Robinson....Ocala
Mrs. Franklin W. Roush....St. Petersburg
Mrs. Ralph Russell....Ocala
Mrs. E. T. Sellers....Jacksonville
Mrs. Denise Shields....Bradenton
Mrs. E. F. Shaver....Tampa
Mrs. T. K. Slaughter....Oxford
Mrs. H. D. Smith....Sanford
Mrs. W. H. Spiers....Orlando
Mrs. J. S. Stewart, Jr.....Miami
Mrs. J. L. Strange....McIntosh
Mrs. J. A. Strickland....St. Petersburg
Mrs. J. L. Summerlin....Gainesville
Mrs. J. E. Taylor....DeLand
Mrs. Joe Ivey Turberville....Century
Miss Kathleen Turberville....Century
Miss Susan Upchurch....Jacksonville
Mrs. N. A. Upchurch....Jacksonville
Mrs. L. H. Von Engelken....Ocala
Mrs. E. W. Veal....Jacksonville
Mrs. J. C. Vinson....Tampa
Mrs. F. J. Waas....Jacksonville
Mrs. T. H. Wallis....Ocala
Mrs. Harrison A. Walker....Miami
Mrs. Herman Watson....Lakeland
Mrs. Walter A. Weed....Lakeland
Mrs. J. Ralston Wells....Daytona Beach
Mrs. H. V. Weems....Sebring
Mrs. W. J. Williams....Seville
Mrs. A. K. Wilson....Jacksonville
Mrs. J. F. Wilson....Lakeland
Mrs. Evans B. Wood....Daytona Beach
Mrs. S. C. Wood....Leesburg
Mrs. B. F. Woolsey....Jacksonville

OUR PRESIDENT

Herbert Lee Bryans, son of the late Dr. Robert L. Bryans, was born in Griffin, Georgia, September 16, 1889. He moved to Florida in his early childhood, where he attended the public schools of Escambia County and obtained his preparatory work at the Pensacola Classical School. In 1911, Doctor Bryans graduated from the Emory University School of Medicine (Atlanta College of Physicians and Surgeons), and during the following year did post-graduate work in internal medicine at the New York Post-Graduate Medical School.

In 1913, Doctor Bryans returned to Pensacola where he began the practice of medicine. After the declaration of war, he was commissioned First Lieutenant in the Medical Reserve Corps, U. S. Army and attended a Course of Instruction at the Army Medical School, Washington, D. C., in May and June, 1917. He was ordered overseas in July, 1917, on detached duty with the Royal Army Medical Corps. He was later commissioned Captain and Major.

After being discharged from the Army in July, 1919, Doctor Bryans accepted a position with the U. S. Veterans Bureau, Washington, D. C., becoming an associate member of the board of appeals and later, when the decentralization took place, he was assigned to the New Orleans office as chief of the medical rating section. After organizing the rating section, he was transferred to the Mount Alto Tuberculosis Sanatorium, Mount Alto, Pennsylvania, as chief of the medical service where he remained for one year. In 1923, Doctor Bryans resigned from the government service to resume private practice in Pensacola.

Doctor Bryans is a member of the Masonic Fraternity, Rotary Club, Escambia Club, and a member of the American College of Physicians. He is a charter member of the Rho Chapter Theta Kappa Psi Medical Fraternity.



DOCTOR HERBERT L. BRYANS, OUR PRESIDENT

Florida Medical Association, Inc.

Officers

HERBERT L. BRYANS, M.D., President *Pensacola*
O. O. FEASTER, M.D., President-elect *St. Petersburg*
EUGENE G. PEEK, M.D., First Vice-President *Ocala*
J. W. ALSOBROOK, M.D., Second Vice-President . . . *Plant City*
J. S. TURBERVILLE, M.D., Third Vice President *Century*
SHALER RICHARDSON, M.D., Secretary-Treasurer . . *Jacksonville*

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THE OCALA MEETING

The Marion County Medical Society, which acted as host to the Sixty-Second Annual Meeting of the Florida Medical Association, held in Ocala, May 13, 14 and 15, is to be congratulated. The attendance at this meeting ranked third in the history of the Association. In 1934, Jacksonville had the largest attendance with a total of 617; Orlando in 1931 was second with a total of 502. The registration this year at Ocala totaled 472. Of this number, 311 were members of the State Association, 27 were visitors, 22 representatives at exhibit booths and 112 Woman's Auxiliary.

The members of the Marion County Medical Society deserve unusual credit for entertaining such a large number at the recent convention. Members of local committees and, in fact, each member of the Marion County Medical Society, including the members of the Woman's Auxiliary, were, indeed, real hosts. Everyone attending this convention in Ocala was more than pleased with the entertainment and hospitality displayed. The officers of the Marion Hotel were most cordial and looked after the convenience of guests to the best of their ability. The Secretary of the local Chamber of Commerce was on the job every minute and everything possible was done to make the members and guests enjoy their stay in Ocala.

Twelve exhibit spaces were occupied in the Marion Hotel and the representatives of the various exhibiting firms filled an important part in making this meeting a success. Owing to the lack of space, it was necessary to turn down applications of many worth-while firms who desired exhibit space.

The Association dinner, held in the main dining room of the Marion Hotel, was a very pleasant affair. The attendance was not up to that of the previous year. This was probably largely due to the fact that many of the members and guests felt there would not be seating capacity for an unusually large number. Two hundred forty-six dinner tickets were sold and the dining room was ample to accommodate this number. The menu was carefully selected and the service and food were of the highest order.

Complete proceedings of the meeting, as well as the names of the new officers, appear in this Journal. Committee appointments were not completed when this Journal went to press so a complete list of the committee appointments will appear in the July Journal.

BIOGRAPHICAL SKETCHES OF PHYSICIANS GIVING SHORT COURSE*

DR. EMIL NOVAK

The lectures on gynecology will be given by Dr. Emil Novak, Associate in Gynecology at Johns Hopkins Medical School. Dr. Novak received his A. B. degree from Loyola and his M. D. degree from the University of Maryland. He is visiting gynecologist to St. Agnes' and Bon Secours Hospitals, Hospital for the Women of Maryland. He is a Fellow and former Vice President of the American Gynecological Society; Fellow American Association Obstetricians; Gynecologists, and Abdominal Surgeons; former Chairman Section on Obstetrics, Gynecology, and Abdominal Surgery, American Medical Association; Fellow Southern Surgical Association; American Association for Study of Internal Secretions, Southern Medical Associa-

*Biographical sketches of other faculty members will appear in the June Journal.

PROGRAM OF GRADUATE SHORT COURSE, JUNE 24-29, 1935

Hours	Monday, June 24	Tuesday, June 25	Wednesday, June 26	Thursday, June 27	Friday, June 28	Saturday June 29
9:00-10:00	Pediatrics Casparis	Medicine Bethea	Pediatrics Casparis	Gynecology Novak	Gynecology Novak	Surgery Shipley
10:00-11:00	Obstetrics Adair	Obstetrics Adair	Obstetrics Adair	Surgery Shipley	Surgery Shipley	Gynecology Novak
11:00-11:30	Recess	Recess	Recess	Recess	Recess	11:00-12:00 Orthopedic Surgery Campbell
11:30-12:30	Medicine Bethea	Pediatrics Casparis	Medicine Bethea	Orthopedic Surgery Campbell	Orthopedic Surgery Campbell	
12:30- 2:00 Lunch hour Round-table Discussion	Chairman: Casparis	Chairman: Bethea	Chairman: Adair	Chairman: Shipley	Chairman: Novak	12:00- 1:00 Surgery Shipley
2:00- 3:00	Obstetrics Adair	Obstetrics Adair	Venereal Diseases Wenger	Gynecology Novak	Surgery Shipley	
3:00- 3:15	Recess	Recess	Recess	Recess	Recess	
3:15- 4:15	Medicine Bethea	Pediatrics Casparis	Medicine Bethea	Surgery Shipley	Gynecology Novak	
4:15- 5:15	Pediatrics Casparis	Medicine Bethea	Obstetrics Adair	Venereal Diseases Wenger	Venereal Diseases Wenger	
8:00-		Alachua Co. Medical Soc. Smoker: Symposium, Malaria		Lecture on Social Diseases Wenger		

tion. He is engaged in active gynecological practice and teaching.

Dr. Novak is author of "Menstruation and Its Disorders" (D. Appleton and Company); "The Woman Asks the Doctor" (Williams and Wilkins Company); Section on Physiology of Reproduction in Curtis' "Obstetrics and Gynecology"; Chapter in Kelly's "Gynecology," Lewis' "System of Surgery," Adair and Stieglitz's "Obstetric Medicine." He has published about 175 papers, dealing chiefly with pathological, physiological, and endocrinological aspects of gynecology.

Dr. Willis C. Campbell

The course in orthopedic surgery at the Short Course in June will be presented by Dr. Willis C. Campbell, Professor of Orthopedic Surgery at the University of Tennessee School of Medicine, Memphis, Tennessee, since 1910. Following his graduation from the University of Virginia Medical School in 1904, Dr. Campbell took post graduate work at the Royal National Orthopedic Hospital, London, the University of Vienna, and other European clinics.

Dr. Campbell is chief of staff of the following hospitals: Dr. Willis C. Campbell Clinic, Crippled Children's Hospital, and Hospital for Crippled Adults. He is a member of the American Orthopedic Association, American Academy of Orthopedic Surgeons, International Society of Orthopedic Surgery, American College of Surgeons, American Medical Association, Southern Surgical Congress, Southern Medical Association, Clinical Orthopedic Society, and Interurban Orthopedic Club.

Dr. Campbell is author of the following publications: "Orthopedics of Childhood," a monograph in Clinical Pediatrics, D. Appleton and Company, 1927; "Injuries and Surgical Diseases of the Joints," a chapter in Dean Lewis' "Practice of Surgery," W. F. Prior and Company, 1928; "Dislocation of Joints," same series as above, 1930; "Physical Therapy in Bone and Joint Tuberculosis," a chapter in "The Principles and Practice of Physical Therapy," W. F. Prior and Company, 1932.

The subjects selected by Dr. Campbell for his lectures in June are "The Fracture Problem," "Surgery of Arthritis," and "Osteomyelitis," all illustrated by lantern slides and motion picture films.

STATE NEWS ITEMS

Dr. Hewitt Johnston of Orlando has returned from Roanoke, Virginia, where he took a post-graduate course in eye, ear, nose and throat work.

* * *

Dr. J. J. Regan of Boston, Mass., was recently the guest of Dr. and Mrs. S. B. Forbes of Tampa. Dr. Regan was recently elected president of the New England Ophthalmological Society. He is head of the Eye Department of the Boston City Hospital. While in Tampa, he gave a talk before the Eye, Ear, Nose and Throat Society on "Acute and Chronic Dacryocystitis."

* * *

The many friends of Dr. W. M. Goodson of Miami wish him a speedy recovery. Dr. Goodson is a patient at the Jackson Memorial Hospital.

* * *

The annual meeting of the Academy of Physical Medicine will be held June 12 and 13, at the Claridge Hotel, Atlantic City, N. J. For further details, address Arthur H. Ring, M.D., Secretary, Arlington, Mass.

* * *

Doctor and Mrs. Joseph M. Bosworth of Lakeland spent a week during the month of April in Atlanta, as guests of Doctor Bosworth's parents.

* * *

Dr. Peter W. Besenbruch and family of Davenport sailed from New York on May 23 on a trip to Germany. They will visit relatives and Doctor Besenbruch expects to do post-graduate work in that country before returning home.

* * *

The American Proctologic Society will hold its thirty-sixth annual meeting in Atlantic City June 10 and 11. Headquarters for the meeting will be the Marlborough-Blenheim.

* * *

Dr. J. A. B. Sinclair of Miami died at the St. Francis Hospital, Miami Beach, May 19, from heart trouble.

* * *

The American Association for the Study of Goiter will hold its annual meeting in Salt Lake City, Utah, June 24-26. A well-rounded program has been planned.

* * *

Dr. Corbett E. Tumlin of Miami, a member of the Florida State Board of Medical Examiners, has been appointed a Kentucky Colonel by the Governor of that state.

* * *

Dr. M. D. Thomas of Miami Beach is spending the summer at Old Orchard Beach, Maine. He expects to return to Florida about September 10.

* * *

The sixth annual and quarterly meeting of the Florida Dermatological Society will be held in Jacksonville the week-end of June 30.

Dermatologists from most of the southeastern cities have accepted an invitation to attend this clinical meeting for the purpose of organizing the South Atlantic Dermatological Conference.

Chairman—J. L. Kirby-Smith, Jacksonville.

Secretary—J. J. Saxton, Tampa.

* * *

Dr. William Henry Watters, who spends each winter at Coconut Grove, has returned to Boston, Mass. His address is 270 Commonwealth Ave.

* * *

Dr. L. M. Anderson of Lake City has opened offices in the Lake City Pharmacy Building.

* * *

Dr. George Dame of Inverness was recently elected head of the Grand Chapter of Royal Arch Masons of the State of Florida.

* * *

Dr. H. C. Babcock of Miami died May 26. Dr. Babcock, who was 61 years of age, was a native of Mason City, Iowa. He came to Miami in 1913 where he practiced up until the time of his death.

* * *

Doctor and Mrs. Henry Palmer of Tallahassee were visitors in Jacksonville recently. Doctor Palmer called at the business office of the Florida Medical Association and also spent some time at Atlantic Beach.

* * *

The Committee on Arrangements for the next annual meeting, which is to be held on the S.S. Florida, will have some very interesting information in the editorial column and the advertising pages of the June Journal. Beginning with the June Journal, and continuing from time to time, attractive information will be available in your Journal.

FOR SALE—Victor X-ray, hospital size, 1922 model. Buckeye extension, developing equipment. Operating table, instrument table, gas dry goods and instrument sterilizer. Complete set abdominal surgical instruments. Any reasonable price accepted. Mrs. C. C. Bohannon, 154 First Avenue, Daytona Beach.

COMPONENT COUNTY SOCIETIES

DADE COUNTY MEDICAL SOCIETY

The Dade County Medical Society held its regular meeting in the Huntington Club Rooms, 8:30 p. m., May 3. The following symposium on "Cancer of the Uterus and Cervix" comprised the scientific program:

"Etiology," John T. McDonald.

"Pathology," Buist Litterer.

"Methods of Diagnosis," J. R. Graves.

"Carcinoma of the Fundus," M. H. Tallman.

"Radiation Therapy," Gerard Raap.

"Complications," M. M. Coplan.

DE SOTO-HARDEE-HIGHLANDS COUNTY MEDICAL SOCIETY

The regular monthly meeting of the DeSoto-Hardee-Highlands County Medical Society was held in Wauchula April 9th, with the following members present: Kirkpatrick, Pyatt, Kayton, Bevis, Chandler, J. A. Simmons, Peacock, Weems, and Martin. Visitors: Dr. Mason Smith, Dr. Bundy Allen, and Dr. Leland Carlton of Tampa, and Dr. Peacock of Bartow.

The committee composed of Simmons, Kirkpatrick and Martin to contact Senator Murphey regarding medical legislative and Social Security Bill, reported having met with him in Arcadia and had lunch with him and Representative Sims of Highlands County. Both were in favor of any changes the doctors saw fit. Representatives in DeSoto and Hardee were reported contacted.

Dr. Weems read a letter from Dr. Davis of Quincy regarding medical legislative program. This was discussed by Dr. Mason Smith. Dr. Simmons made motion that society go on record as opposed to the Social Security Act and that all representatives in the three counties and Senator Murphey be wired to this effect.

Dr. Mason Smith of Tampa made a most interesting talk on "Encephalograms," supplemented by many x-ray pictures and discussed by Dr. Bundy Allen of Tampa. Dr. Carlton of Tampa also discussed this paper.

It was moved by Dr. Simmons and seconded by Dr. Poucher that no monthly meeting be held in May due to the state meeting in Ocala. The question was brought up of changing the hour of meeting from 8 to 6:30 or 7 p. m., but no one was interested enough to discuss it. There being no further business, the meeting adjourned.

LAKE COUNTY MEDICAL SOCIETY

A meeting of the Lake County Medical Society was held in Leesburg, April 3. Dr. C. D. Hoffman of Orlando, guest speaker at this meeting, presented a paper on "Sterility."

LEE COUNTY MEDICAL SOCIETY

THE LEE COUNTY MEDICAL SOCIETY HAS PAID 100% OF DUES FOR 1935. THE OFFICERS RESPONSIBLE FOR THIS ACHIEVEMENT ARE:

President—ERNEST BOSTELMAN.
Vice-President—W. H. GRACE.
Sec'y-Treas.—H. QUILLIAN JONES.

PASCO-HERNANDO-CITRUS COUNTY MEDICAL SOCIETY

The regular monthly meeting of the Pasco-Hernando-Citrus County Medical Society was held at the Tangerine Hotel in Brooksville, Thursday evening, April 11. Dr. A. C. Coogler was the host. An excellent dinner was served which was followed by the regular business and scientific meeting.

The following members were present: Dr. S. C. Harvard, Dr. A. C. Coogler, Dr. G. R. Creekmore of Brooksville; Dr. Leland H. Dame and Dr. Geo. A. Dame of Inverness, and Dr. J. T. Bradshaw and Dr. John J. Bourke, of Dade City.

POLK COUNTY MEDICAL SOCIETY

THE POLK COUNTY MEDICAL SOCIETY HAS BECOME THE THIRTEENTH SOCIETY TO REPORT 100% OF DUES PAID FOR 1935. SEVEN NEW MEMBERS HAVE BEEN ADDED TO THE ROSTER OF THIS SOCIETY, MAKING A MEMBERSHIP OF 57. THE OFFICERS OF THIS SOCIETY ARE:

President—R. L. HUGHES, BARTOW.
Vice-President—G. C. FREEMAN, LAKELAND.
Sec'y-Treas.—J. R. BOULWARE, JR., LAKELAND.

WOMAN'S AUXILIARY

TO THE
FLORIDA MEDICAL ASSOCIATION, INC.

State Editor
Mrs. S. M. Copeland
1356 Willowbranch Ave.,
Jacksonville, Florida

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Mrs. Gordon Ira, Program *Jacksonville*
Mrs. E. R. McMurray, Public Relations *Bartow*
Mrs. John E. Maines, Hygeia *Gainesville*
Mrs. L. C. Ingram, Finance *Orlando*
Mrs. S. M. Copeland, Press and Publicity *Jacksonville*

The ladies attending the State Medical Convention held in Ocala May 13, 14, 15, were delightfully entertained by the Marion County Auxiliary.

On Monday evening a double feature entertainment was staged. Some of the ladies attended a theatre party at the Ritz Theatre, while others attended a bridge party in the beautifully adorned loggia of the Highlands Hotel and Club House. Those attending the bridge party, created quite a bit of excitement when they roared through the town in ambulances from three undertaking establishments with the sirens open and escorted by a police patrol.

At a late hour the theatre party joined the bridge players for a delightful buffet supper in the beautiful dining room of the Highlands Hotel.

On Tuesday morning the annual business meeting of the State Medical Auxiliary was held in the dining room of the Marion Hotel and the following State Officers were elected: Mrs. E. W. Veal of Jacksonville, president; Mrs. W. W. Harden of St. Petersburg, president-elect; Mrs. J. Ralston Wells of Daytona Beach, vice-president; Mrs. Walter Weed of Lakeland, last year's secretary and treasurer, was re-elected, and Mrs. Leigh F. Robinson of Ft. Lauderdale, corresponding secretary.

Mrs. E. G. Peek of Ocala was re-elected State Historian and Mrs. Wilburn Lassiter of Gainesville was re-elected parliamentarian of the organization. The following are the retiring officers of the State Auxiliary: Mrs. E. R. McMurray of Bartow, president; Mrs. Homer Pearson of Miami, vice-president, and Mrs. G. C. Tillman of Gainesville, corresponding secretary.

The new president of the State Auxiliary, Mrs. E. W. Veal, was presented the gavel by the retiring president, Mrs. E. R. McMurray, who expressed her appreciation for the cooperation shown her by the officers and members of the organization during the year. Mrs. Veal appointed the following committee chairmen who will serve during her administration: Mrs. S. M. Copeland, of Jacksonville was reappointed State Press and Publicity chairman; Mrs. Gordon H. Ira of Jacksonville, State Program chairman; Mrs. John Maines of Gainesville, State chairman of "Hygeia" magazine; Mrs. E. R. McMurray of Bartow, State chairman of Public Relations, and Mrs. L. C. Ingram of Orlando, State chairman of Finance.

The meeting was opened by Mrs. R. D. Ferguson, president of Marion County Auxiliary, who asked the members to stand and to read in unison the Club Woman's Collect. Mrs. Ferguson then introduced the State president, Mrs. E. R. McMurray, who took the chair. Mrs. Walter Hood of Ocala gave the welcoming address and Mrs. S. M. Copeland of Jacksonville gave the response.

Mrs. McMurray introduced Dr. Homer Pearson of Miami, State president of the Florida Medical Association, who spoke on Organized Medicine. He assured the auxiliary members that he knew they would do everything in their power to make the communities in the State healthier and happier places in which to live. Dr. Pearson urged the auxiliaries through their own medical associations to become more interested in what was going on in politics, saying that unless they did so the medical profession would be at the mercy of unscrupulous laws. "The success of a community, a people, or a nation depends upon what motives drive it," Dr. Pearson stated. "Those in the medical associations and auxiliaries should have aims which will be of mutual advantage to all of those concerned. The men belonging to the medical associations are helpless," he said, "without the aid and encouragement of the women."

"The second project of the Medical Association beside that of more adequate organization is the study of maternal welfare," the speaker said further. He pointed out that in the United States the maternal mortality rate is as high as that of any civilized nation and that the death rate from maternity cases in Florida is the highest of any state in the union. "The lax laws of Florida," said Dr. Pearson, "permit almost any

one to assume the responsibility of a woman at the time of child birth. Too many women in our state do not have the right attention at this most important time of their lives. This is a most serious indictment against those practicing midwifery in this State."

Dr. Pearson informed the women present at the morning's meeting that a committee had been appointed to investigate every maternal death in this state, to determine the exact causes and to do everything in its power to eradicate them. "We must have laws in this state," the speaker insisted, "so that it will be impossible for incompetent persons to take care of women during pregnancy." The physician said in conclusion, that with the assistance of the University of Florida the Medical Association is attempting to instigate a graduate course for doctors at the institution.

Mrs. McMurray introduced Dr. Gordon H. Ira, chairman of the State Medical Advisory Board, who spoke on the "Expansion of the Organization." Dr. Ira stated there are 24 possible unorganized auxiliaries in the state, and in order to achieve organization, a good deal of hard, concentrated work, time, money and careful planning are needed. Dr. Ira said that in order to insure the most success there must be definite plans of activity for the as yet unorganized auxiliaries. The doctor spoke briefly upon some of these activities. He pointed out the need for wholehearted cooperation in the cancer prevention program, saying that illustrated lectures on this subject are easily available through Dr. Gerry R. Holden, of Jacksonville.

Dr. Ira also urged the boosting of the magazine "Hygeia" and the medical examination of servants before they enter into service. "It is pure folly," he said, "to engage the services of these people who take care of our children and handle our food without adequate medical examinations." He cited specific cases of terrible disease found among servants who could easily pass them on to those in the household.

Following these two interesting speeches there were various committee reports and an introduction of the members of the newly organized auxiliary in Orange County, of which Mrs. L. C. Ingram of Orlando is president.

Respect was shown Mrs. Shaler Richardson of Jacksonville, Mrs. J. L. Chalker of Ocala, and Mrs. Marie Rountree of Ocala, who passed away since the last convention, by rising for a moment in silent meditation with bowed heads.

A general vote of thanks was extended the hostess auxiliary and all who contributed so loyally to the entertainment of the doctors' wives during the convention by the resolutions committee, as follows:

RESOLUTION

We, the ladies of the Woman's Auxiliary to the Florida Medical Association, in convention assembled, wish to express our sincere thanks and deep appreciation to the members of the Marion County Auxiliary for their wonderful hospitality and entertainment that have been extended to us at this 1935 meeting.

We wish to extend our thanks to Mrs. Ferguson, the President of the Hostess Auxiliary, to Mrs. Lindner, the Social Chairman, for their untiring efforts in making the convention a great success and one long to be remembered. We also wish to thank Mrs. Peek and Mrs. Wallis for the beautiful corsages and the local undertakers for their contribution to our entertainment; to Miss Mary Burford and Miss Nina Camp for the lovely decorations at the luncheon.

Be It Therefore Resolved: That a general vote of thanks be extended to these ladies.

Respectfully submitted,

Mrs. John Wilson, Chairman;
Mrs. Edward Jelks,
Mrs. Leigh F. Robinson.

Following the business meeting the women enjoyed a delicious luncheon at Silver Springs where they were guests of the Marion County Auxiliary. The tables were decorated beautifully with early summer flowers carrying out a color motif of blue and yellow, the tasteful work of Miss Nina Camp and Miss Mary Burford. At this time the past president and the newly elected officers were presented with attractive corsages. The favors were little Indian pottery vases beautifully wrapped in blue and yellow cellophane.

Immediately following the luncheon, the women were given a delightful trip down Silver Springs River in glass-bottom boats.

A banquet for the doctors and their wives in the Marion Hotel dining room followed by a dance, closed the convention.

Much credit is due Mrs. E. G. Lindner, Mrs. R. D. Ferguson, Mrs. J. N. Moore, Mrs. Walter Hood, Mrs. E. G. Peek, Mrs. T. H. Wallis and others who contributed to the lovely entertain-

ment of the doctors and their wives. One hundred and twelve ladies attended the convention. The registration is shown on page 515 of this Journal.

Mrs. Robert W. Tomblinson, president, requests that an announcement be made of the annual meeting of the American Medical Auxiliary to be held in Atlantic City June 10, 11, 12, with the Ambassador Hotel as headquarters for the American Medical Association, and Haddon Hall for the Canadian Medical Society and the Traymore for the Auxiliary. It is on the Board Walk, not far from the huge Convention Hall where all of the men's meetings, the scientific and commercial exhibits will be held.

Mrs. Tomblinson says: We are looking to each and every state group to get their membership and their dues up to date by the end of the fiscal year. Paid up memberships will play a great part in our Atlantic City meeting. Dr. Carrington is the chairman for the convention and is so full of plans and enthusiasm for the meeting when you get there you will realize the spirit that has made this one of the best meetings ever held.

Our hope is to make the most of the many attractions that are Atlantic City's alone. The piers, the walk, the sea food, the sun and sea air combined with splendid hotels and a spirit of welcome that is unsurpassed, our Canadian visitors and our own pleasure at renewing old friendships will provide us with an opportunity to accomplish much, to play hard and go home refreshed by our stay in our country's greatest seashore resort.

Will every state president who reads this remember that each of the state chairmen must render a report to the national chairman, so that she may be ready to give a complete report at the meeting in June The reports must be in the hands of a properly accredited delegate in order to have it read at the meeting, otherwise, it is placed on file and printed in the report of the meeting. We will appreciate your understanding this, and we hope that each state will have some one there to read its report so that the full program of activities will have proper recognition.

We are all volunteer workers and are doing the best we can, and no one appreciates more than I the wonderful work that is being done. I am sure that when the final summation is made we will be truly thrilled with it.



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DADE COUNTY AUXILIARY

The Woman's Auxiliary to the Dade County Medical Society met at the home of Mrs. Arthur Weiland in Coral Gables on April 8th. A covered dish luncheon was served at noon. The president, Mrs. H. A. Leavitt, presided at the business meeting following the luncheon. Pamphlets of "Health by Blueprint" and "Modern Weapons to Fight Tuberculosis" were distributed among the members.

Plans were discussed concerning the dinner dance to be held in May. Mrs. H. A. Leavitt and Mrs. F. A. Gowdy were made delegates to the Florida State Medical Convention to be held on May 13, 14 and 15th.

RESOLUTIONS

Resolutions of regret in the death of Mrs. Helen Hare Richardson on March 25 have been adopted by the Woman's Auxiliary to the Duval County Medical Society, of which she was an active member.

The Resolutions follow:

Mrs. Richardson was born January 10, 1900, in this city and attended the public schools in Jacksonville and Springfield School in Chestnut Hill, Pa., and National Park Seminary in Washington, D. C.

Mrs. Richardson was the daughter of the late H. C. Hare, long prominent in the insurance business of this city and state, and Mrs. Nellie Teynac Hare of Savannah, Ga.

In addition to her widower and mother, Mrs. Richardson is survived by three children, Montcalm, Helen and Arnold. She was an active member of the Sanctuary Guild of the Church of the Good Shepherd and the Junior League.

She was exceptionally active in the church and social circles of Jacksonville and hundreds of friends here as well as in other sections of the State will mourn her passing.

THEREFORE, BE IT RESOLVED, That the Woman's Auxiliary has lost one of its most valuable members.

And, whereas, we feel that one of us, whose guidance and high ideals set a standard by which we are all striving to govern ourselves, has been taken from among us.

And, whereas, Mrs. Richardson endeared herself to many Jacksonville citizens and others throughout the State for her many graces and most charming personality.

THEREFORE, BE IT RESOLVED: That a copy of

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Some Clinical Observations on the Influence of certain Hygroscopic Agents in Cigarettes.
Laryngoscope, 1935, XLV, 149-154★

SEE ALSO

Pharmacology of Inflammation: III. Influence of hygroscopic agents on irritation from cigarette smoke.
Proc. Soc. Exp. Biol. and Med., 1934, 32, 241-245★



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★ **Reprint of papers from Laryngoscope 1935 XLV, 149-154 and from Proc. Soc. Exp. Biol. and Med., 1934, 32, 241-245.** ☐

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these resolutions be spread upon the minutes of the Woman's Auxiliary and a copy of these resolutions be extended to the bereaved family to whom we extend our deepest heartfelt sympathy.

Respectfully submitted,

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Mrs. S. M. Copeland,
Mrs. O. P. Broadbent.

* * *

ORANGE COUNTY AUXILIARY

On April 2, 1935, an organization luncheon of the Woman's Auxiliary of the Orange County Medical Society was held in Orlando. A very enthusiastic group of twenty women were present and signed as charter members. Constitution and by-laws were adopted and a full corps of officers elected: Mrs. L. C. Ingram, President; Mrs. W. H. Spiers, 1st Vice-President; Mrs. Claude Anderson, Corresponding Secretary; Mrs. Sam Ricker, Recording Secretary; Mrs. Frank Gray, Treasurer; and Mrs. Robt. Wood, Historian.

Delegates elected to the state meeting were the president, Mrs. L. C. Ingram, and Mrs. Julia Buff, with Mrs. Haynes Brinson and Mrs. Spencer Folsom as alternates.

Mrs. E. R. McMurray of Bartow, State President, gave an interesting talk on the founding of these organizations and the duty of its members, including a short resumé of work being done by other societies over the state.

April 23 another meeting was held for further plans for the work of the Auxiliary.

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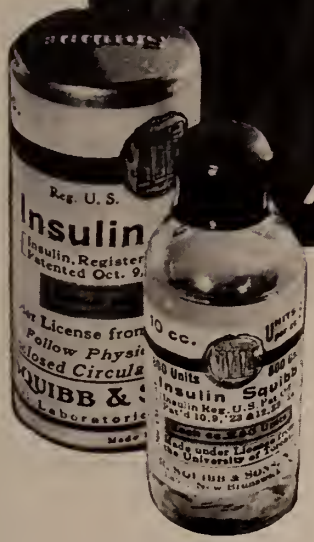
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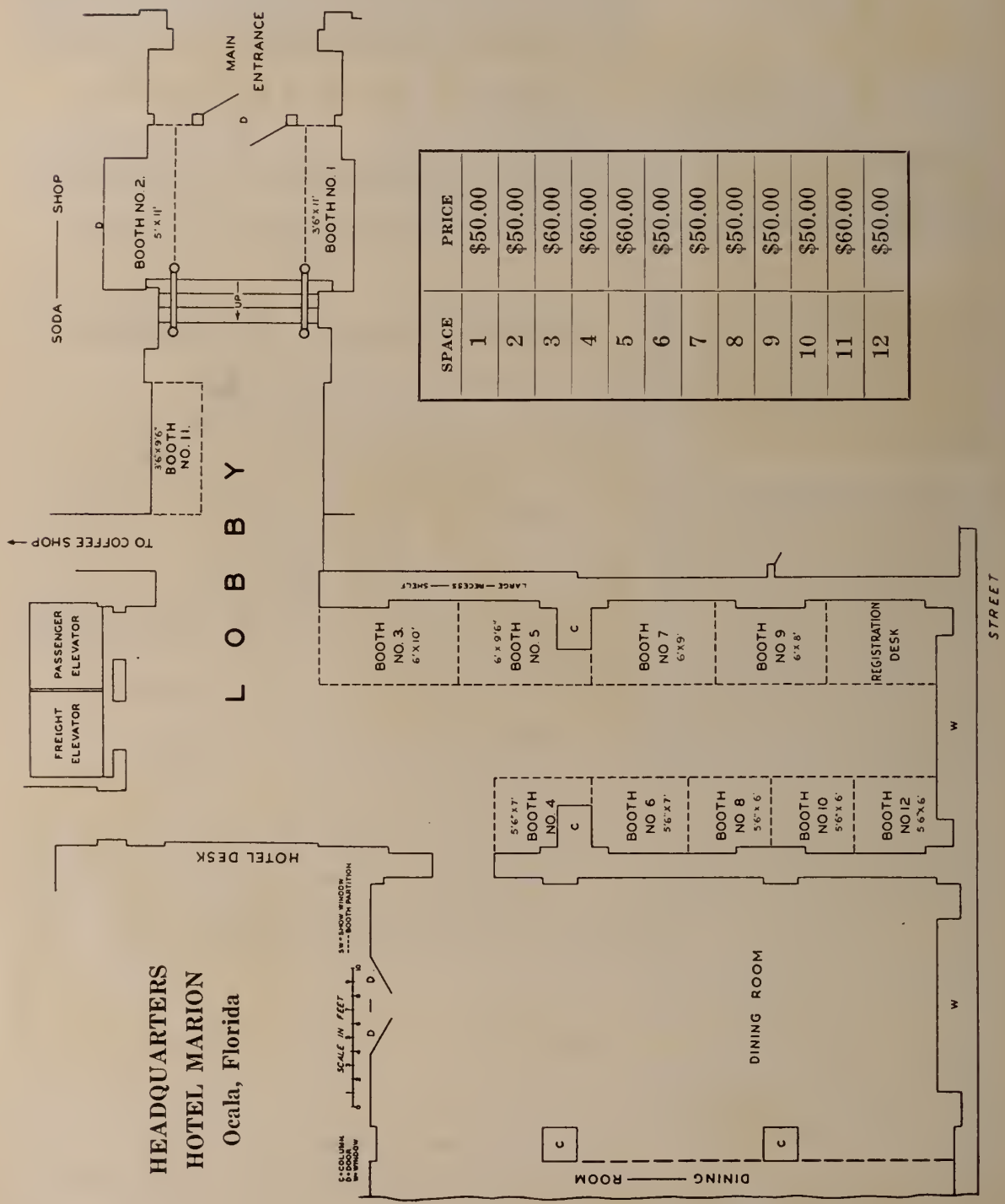
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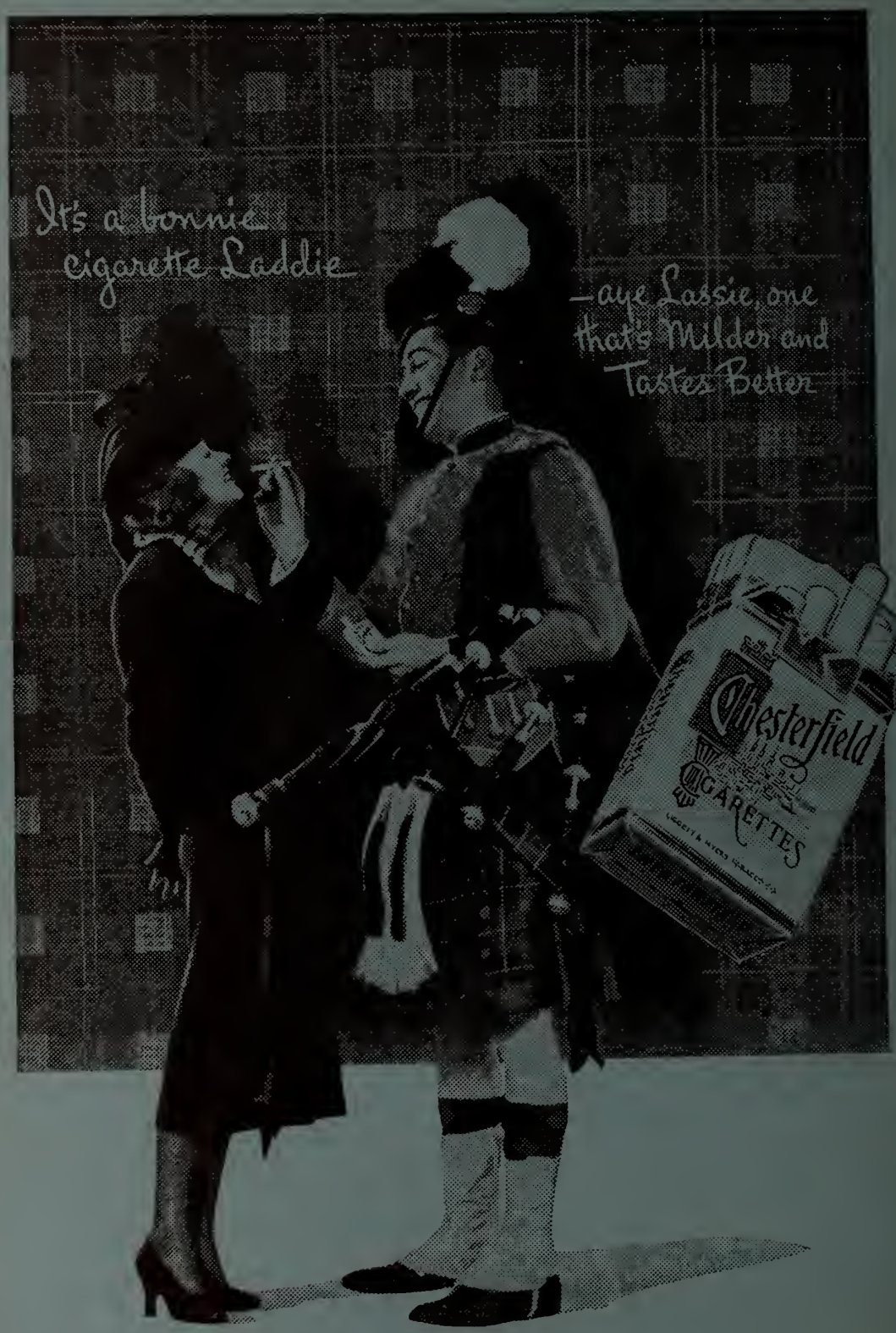
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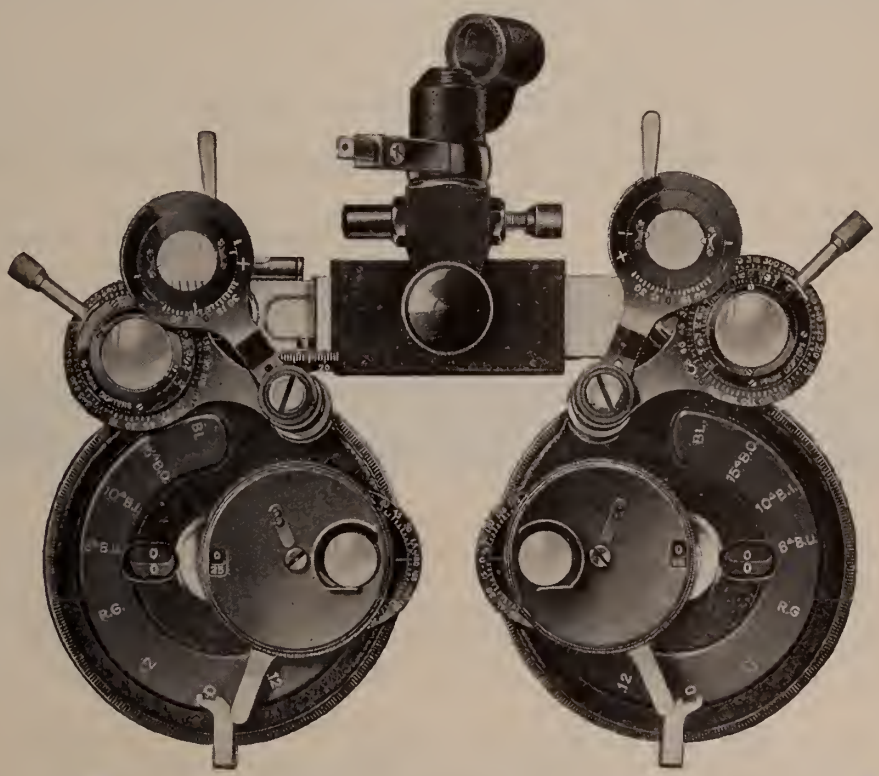
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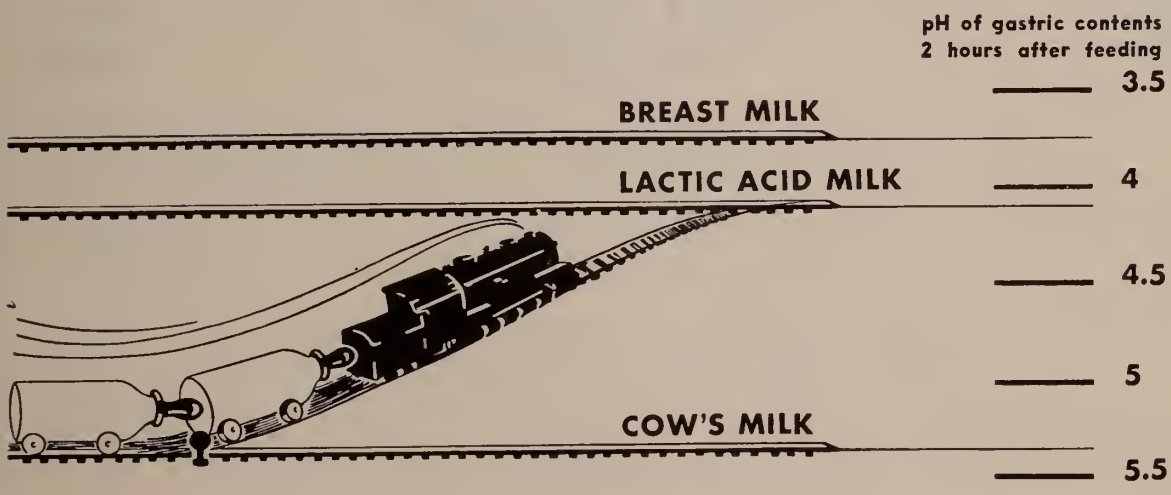
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PEPTIC ULCER FROM A MEDICAL STANDPOINT*

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I think it is well, occasionally, to take stock of our knowledge of certain diseases and to familiarize ourselves with the more recent investigations and advances made in these diseases. Only a few years ago it was thought that women had peptic ulcer two or three times as often as men, and that gastric ulcers were more common than duodenal ulcers. We now know that the opposite is true in both instances.

A few years ago I was working on the gastrointestinal service at St. Mary's Hospital at the Mayo Clinic and at that time 2,641 cases of dyspepsia which had come to operation were tabulated, disregarding the preoperative diagnosis; 20% of these operations were for duodenal ulcer and 5% were for gastric ulcer. Eusterman[1] says: "During 1923 there came under our observation 280 cases of chronic gastric ulcer, as compared with 1,440 cases of duodenal ulcer. So the ratio is almost 1:5." Rehfuss[2] says: "Ulcers of the duodenum affect men more frequently than women; probably in the proportion of 4 or 5 to 1." He does not, however, think the difference is so great in gastric ulcers.

Peptic ulcer is a disease of early adult life; occurring most often during the third and fourth decades, the average age being about forty. Peptic ulcers are usually single, but may be multiple, and they vary considerably in size. The newer ulcers are superficial, involving only the mucous membrane and the submucous tissue, while the older ulcers, crater-like and fibrous, extend deeply into the muscle, often to the peritoneum and sometimes through it.

It is probable that a number of factors contribute to the formation of peptic ulcers. It is now a well established fact that focal infection is an important etiological factor. Rosenow[3] in 1913 was able to produce peptic ulcers in animals by the intravenous injection of streptococci of a certain virulence. Local conditions and systemic resistance both play important parts: local nerve disturbance of a tropic character, or perhaps increased activity of the vagus. With those who live intensive lives with much nervous and mental strain and a, more or less, continued high gastric acidity there is a predisposition to ulcer formation. All factors which lower general resistance may be contributory.

At times, perhaps, the formation of peptic ulcer may be due to local disturbance of the circulation in the mucosa associated with perivascular round cell infiltration, the result of lodgement and proliferation of streptococci in the perivascular spaces and, perhaps, associated with thrombosis of small vessels resulting in the formation of areas of necrosis or necrobiosis in the mucosa where is permitted acidification of the parenchyma cells and their digestion by the pepsin of the gastric juice. Such a process of circumscribed infiltration might be analogous to the process of petechia formation which occurs in certain acute infections.

It is my conception that there are two factors conjointly active in the formation of peptic ulcer;—vascular infarction and subsequent erosion by the gastric juice. In 1853 Virchow[4] emphasized the importance of the role played by blood vessels in the production of peptic ulcer. The part played by gastroduodenitis, acute and chronic, of unknown origin, in the formation of peptic ulcers is suspected by some but is not known. So long as the circulation of the mucosa is physiological it is protected against the action of the gastric juice, but when its circulation is interfered with the gastric juice may attack it and erosion occur and such erosion may lead to the formation of an ulcer. In the process a vessel may be eroded or exposed in the ulcer, or the erosion may burst through into the neighboring viscera or into the peritoneal cavity. The ulcer may be circular, punched-out or cone shaped, or of variable form, size and position.

The diagnosis of peptic ulcer is not difficult provided the symptoms and signs run true to form. But it is not always so. Perforation may be the first thing to happen—and often times without previous symptoms. However,

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there usually is some previous history, but it may be misleading. In one of my cases—a man, age 45 years—there was an acute perforation of a small gastric ulcer, anterior and near the pylorus, and there were no symptoms of dyspepsia immediately preceding the perforation. Three years before, in Belgium, he had a diagnosis made of cholelithiasis, but after undergoing treatment for a time he became free from symptoms and had no painful dyspepsia until the perforation occurred.

A severe gastric hemorrhage may be the first thing to happen;—or collapse, shock and later tarry stools and a history may then be obtained of a painful dyspepsia which had been neglected.

A most interesting case is reported by Horsley,[5] of which the following is an abstract: "A patient of 34 years had several previous attacks of what appeared to be kidney colic; he was admitted to the hospital with an acute attack, with pain in the upper right side, in the region of the right kidney. The necropsy showed the right kidney floating in liquid containing duodenal and stomach contents. There was a large ulcer on the posterior duodenal wall, which had perforated retroperitoneally and the duodenal and stomach contents had gravitated around the right kidney and into the region of the appendix. The symptoms were at first those of kidney colic and later the symptoms ordinarily found in appendicitis."

In typical cases of peptic ulcer the history is clear cut and expressive. And it is most important in attempting a diagnosis of ulcer to obtain a reliable and comprehensive history. One must know certain things very definitely: the character of the gastric distress and the character of its relief; its exaggeration by acid fruits and coarse vegetables; its location and the time of its occurrence and, whether or not, the symptoms recur in the same manner daily; the whole length of time that gastric distress has existed, in months or years; the length of time the spells of distress have lasted, in weeks or months; the length of time between the spells, when there has been no gastric distress, in weeks or months; the seasonal variation of the spells of gastric distress; and noctural distress, before or after midnight.

The pain when localized, in typical cases, is usually slightly above and to the right of the umbilicus. The distress complained of is a feeling of fulness, pressure or weight, or a gnawing pain of variable severity. The distress appears from one to three hours after eating; it seldom appears later or earlier. It does, however, occur a little earlier in gastric than in duodenal ulcers. The pain frequently lasts until the next meal if not relieved by food or soda. If there is pyloric obstruction pain usually occurs at night. The symptoms last for a variable length of time with definite daily repetition and with food and soda relief, until with treatment and rest, the spell of painful dyspepsia terminates and then there is an interval lasting for weeks, more probably months, when the patient is free from symptoms and can eat a great variety of food without producing gastric distress.

Periods of painful dyspepsia lasting for weeks or months with periods of freedom from gastric distress lasting for weeks or months characterize the course of the disease. Eusterman[6] says: "At the Mayo Clinic the average duration of peptic ulcer was nine years." The ulcer dyspepsia, usually, has a definite seasonal variance; the attacks are more apt to come during change of season, in the Spring and in the Fall. All of this information must be obtained,—and it should constitute a historical background for the diagnostic study.

The unusual things that may happen in peptic ulcer vary the picture; a hemorrhage may occur and there may be vomiting of blood,—or there may be a sudden weakness followed in a day or two by tarry stools. A subacute perforation may occur greatly intensifying the picture of gastric distress. Or, the most feared accident of ulcer may occur; perforation into the free peritoneal cavity, with sudden excruciating pain, vomiting and collapse. Though the symptom-complex is, more or less, typical in most cases one is never justified in making a diagnosis on subjective evidence alone. It should be remembered that in some cases the history is atypical and indecisive.

In the physical examination of the patient there is not much to be learned that would definitely point to ulcer. Though tenderness on pressure is not constant, it is usually found in the epigastrium where the pain is greatest and usually over a small area. Gastric analysis, best done by the fractional method of Rehfuss, is a very valuable aid in diagnosis and it usually shows in cases of peptic ulcer a high acid curve; —and it assists in the differentiation of peptic

ulcer from gastric cancer and other dyspepsias of reflex origin.

The fluoroscope is the most valuable of all mechanical aids and the fluoroscopic examination is the most important part of the roentgen examination. One may observe on the fluoroscopic screen abnormalities of contour and motility and one may frequently visualize, indirectly or directly, the ulcer itself. In many instances one may say from the fluoroscopic examination alone that a peptic ulcer does or does not exist, but in other instances, as has been shown by VonRohde[12] and Duval[13], because of a little deformity of the duodenal bulb or of a certain degree of spasticity of the pylorus, one may be only suspicious of the presence of an ulcer.

Nearly every roentgenologist has developed his own technic. It is my practice, after finishing the fluoroscopic examination, to make three or four films, largely for a matter of record, at fifteen or thirty minute intervals; then a six hour film for gastric retention and an intestinal film the following morning. Of the six hour film for residue, Carman[7] says: "Of course it is to be understood that I do not make diagnoses on six hour retentions. However, it is a valuable contributory finding, since 95% of all residue from the meal indicate a lesion in the stomach or just beyond."

The direct roentgen signs of ulcer are more or less well known but they are sometimes difficult to elicit. In many cases this may be due to lack of experience and special knowledge of roentgen gastrointestinal work. It is my opinion that roentgen examinations of the gastrointestinal tract should be made only by those who have had special study and experience in this branch of medicine.

It is my practice to make a study of the gallbladder by the Graham technic, in all of my gastrointestinal investigations; as in differential diagnosis one of the most important things is to rule out cholecystitis. The administration of belladonna is sometimes required to relax the stomach where pylorospasm is due to reflex causes. Dyspepsia of reflex origin due to cholecystitis, appendicitis, hepatitis and constipation usually can be easily eliminated by the method of study here outlined.

In the treatment of peptic ulcer it is of first importance to control the gastric acidity. I think that those who have used the Sippy treatment and have carried out the directions of the author have met with success; it has been so in my cases. Alkalosis is a possible danger but it can be avoided if no more soda than is needed to control the acidity is administered, which is determined by a frequent analysis of the gastric contents; and if there is an occasional checking up of the carbondioxide tension. Certain modifications of the Sippy treatment are in use. Mucin is administered in conjunction with treatment by Rivers and Vanzant,[8] who seem to think that mucin is probably of great benefit in certain types of cases.

The injection of foreign proteids probably has a distinct value. I have given injections of milk in conjunction with the Sippy treatment, I believe, with good results. Martin,[9] who has written at length of the value of the administration of foreign proteid in the treatment of peptic ulcer, calls attention particularly to the effect of the injections of nonspecific milk on the pain of peptic ulcers.

The daily intramuscular injection for three weeks of 5 c.c. of Larostidin (4% solution of l-histidine monohydrochloride) seems to be a valuable form of treatment except in the older cases. Bulmer[14] gives the result of his treatment as 58% symptomatic cures with the disappearance of abnormal roentgenographic findings; 19% of symptomatic cures with persistence of some radiological abnormality; and 23% of failures.

It is now generally conceded that medical treatment should be undertaken first in all cases of ulcer; except that acutely perforating and many bleeding ulcers are surgical, as are, also, the cases which do not yield to medical treatment. And there is, also, another exception due to the danger of cancerous degeneration in gastric ulcers, which MacCarty[10] says is the most frequent form of cancer. Cancerous degeneration does not occur in duodenal ulcers. Judd[11] says: "In some cases gastric ulcer has been relieved and cured by medical treatment, but on the other hand, certain definitely operable cases of cancer of the stomach have been carried to a hopeless state by this plan, so it seems to me that radical surgical treatment should be carried out if the risk is not too great."

To prevent a recurrence, all focal disease should be eliminated. When apparent cure is accomplished and a modified diet given and alkalis continued for gastric distress, if there is any, and with the avoidance of constipation,

perhaps less tobacco, and the eradication of all focal disease it is to be expected that the patient will remain well.

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DIABETES TREATED BY RADIATION OF THE HYPOPHYSIS*

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The importance of the role of the hypophysis in the metabolism of carbohydrates and the possible bearing of this role on the etiology and treatment of diabetes mellitus has been considered in recent years.

The experimental evidence along this line we owe largely to Houssay[1] and his co-workers. They demonstrated that the glycosuria after pancreatectomy was less marked if the animals had been subjected previously to removal of the hypophysis. They also showed that large doses of an extract of the anterior lobe of the hypophysis given intravenously caused glycosuria and ketonuria in normal dogs.

Barnes et al.[2] showed that the injections of an estrogenic substance (amnioton) may suppress a possible diabetic principle in the pituitary. They evidently formulated this theory upon the evidence that seemed to show that the administration of estrogenic substance may suppress the sex principle in the pituitary.

Among the clinical observations indicating the possible role of the hypophyseal gland in sugar metabolism might be mentioned the fact that in Frohlich's syndrome the deficiency of the gland is accompanied by a considerable increase of the sugar tolerance. There is also the observation that glycosuria occurs at some time during the course of acromegaly in a fairly high percentage of the cases.

Assuming an abnormal diabetogenic action of the hypophysis in cases of diabetes, radiation of the pituitary gland, it was thought, might suppress the over-activity of the gland and have a beneficial effect on the course of the disease.

For the purpose of this study, cases of diabetes in children were selected because of the well known observation that the pancreas in juvenile diabetics reveal no constant pathologic changes. Thus, we would be dealing, as it were, with cases of diabetes not complicated by pathology in the pancreas but essentially of deranged physiology. Then, too, these juvenile patients were free from any evidence of hypophyseal pathology as far as the sexual or skeletal systems are affected by a pathologic hypophyseal secretion or tumor formation.

CASE REPORTS

Case 1.—B. T. The patient was a boy, sixteen years of age with a history of diabetes of two years' duration. The blood sugar averaged 380 milligrams per hundred cc. of blood. He had had severe attacks of coma on several occasions and one of insulin shock. His daily intake of carbohydrate was limited to 100 grams, protein 70 grams and fat 100 grams. He was on a balanced insulin dose of twenty-six units before breakfast and sixteen units after the evening meal. As in other cases of juvenile diabetics, he had to live strictly within the prescribed limits of diet and insulin but maintained a fair degree of nutrition. From January 20 to March 26, 1934, a total of 630 roentgens was given to the hypophysis on the right side of the head and 520 on the left. The factors were as follows: high tension

*Read before Dade County Medical Society, February 2, 1934.

at 200 kilovolts, 4 milliamperes, distance 50 centimeters, filtration one-half millimeter copper and one millimeter of aluminum.

Case II. H. M. A girl of sixteen, well developed and well nourished with a tendency to obesity. Duration of diabetes, eight years. The blood sugar averaged 440 milligrams per hundred cc. of blood. The insulin intake daily was fifty-four units, divided thirty-four units before breakfast and twenty units after the evening meal. The daily diet consisted of 90 grams of carbohydrates, 75 grams protein and 95 grams fat. Radiation of the hypophysis was carried out from January 18 to March 13, 1934, 370 roentgens were administered to each side of the head, the factors remaining the same as in the first case.

Case III. J. S. A girl, twelve years of age. Diabetes of a mild degree, duration slightly over one year. The blood sugar averaged 118 milligrams per hundred cc. of blood and the insulin five units daily and that before breakfast only. The carbohydrate intake was 70 grams, protein 60 grams and fat 100 grams. From March 14 to March 19, 1934 inclusive with the above factors, she received 150 roentgens to each temple.

With the exception of temporary improvement, irradiation has produced no lasting benefit in any of the patients. The insulin dosage has not been diminished and the hyperglycemia and glycosuria are at about the same levels as previous to the radiation. At the present time, about one year from the beginning of radiation treatment, the first two cases represent severe grades of diabetes and require an average respectively, of 42 and 54 units of insulin per day. Even with this dosage of insulin and strict adherence to proper diets, glycosuria and hyperglycemia cannot be controlled constantly. The third case is a mild one, detected less than a year ago and only requires five units of insulin per day to maintain the urine sugar free.

We realize the paucity of the number of cases treated and the fallacy of drawing conclusions therefrom. We are reporting the result of this method of treatment of diabetes with the hope of encouraging others to experiment along similar or different lines. The technique was of our own choosing and although no apparent benefit could be shown, the dosage administered was well below the limit of skin tolerance and no harm resulted.

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LUNG ABSCESS*

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Abscess of the lungs is, fortunately, a rather infrequent disease. However, the fact that when it does occur, in spite of the most advanced methods of treatment, it carries with it a mortality of from 20-60%, makes it a problem well worth considering. As one writer expresses it:

"There are few conditions which, arising often from such trivial and preventable causes as does abscess of the lung, so quickly and completely incapacitate a person, rendering him a burden to himself, his friends, and to society. The progressing weakness, the distressive cough, the long convalescence, and above all, the foul smelling and tasting sputum, break the morale of the stoutest patient and present one of the most difficult conditions to treat."

As early as the time of Hippocrates, the occurrence of lung abscess was recognized and the effects of rupture into a bronchus or into the pleural cavity noted. Since that time many methods of treatment, both medical and surgical, have been advocated and used from time to time. In spite of all the progress in treatment, the high mortality makes it a formidable disease.

The most potent factor in the causation of lung abscess is probably poor oral hygiene. Halpin, et al., report twenty cases of nontuberculous abscess of the lungs, in eight of which dental carries and oral sepsis were definite predisposing factors.

The factor next in importance is probably tonsillectomy under general anesthesia. Wessler says that 28% of 100 cases were due to tonsillectomy. Whittemore reports 17 out of 32 lung abscesses to be due to tonsillectomy. Lung abscess after tonsillectomy is usually due to faulty technique which allows blood, saliva, and material squeezed from the tonsils to be aspirated into the lungs. It also develops after tooth extraction and other operations under general anesthesia. One case studied followed operation upon the knee under ethylene. The fact that lung abscess is very infrequent after local anesthesia

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is brought out by reports of as many as 12,000 and 25,000 tonsillectomies with local anesthesia and without a single lung abscess.

Lung abscess is a rare sequel to lobar pneumonia. It does occur, however, after bronchopneumonia. One case studied came after bronchopneumonia. It also follows a small percentage of traumatic wounds of the chest. It sometimes arises by extension of infection from other organs, such as subphrenic or liver abscess.

The pathological picture of lung abscess varies all the way from the small localized abscess of metastatic origin to the extensive putrid gangrene of a large portion of a lobe. The predominant type, however, is usually a single abscess cavity which may or may not communicate with a bronchus and tends to surround itself with a fibrous wall of varying thickness.

Careful culture and smears from the sputum of a number of cases show that the organisms found in 70 to 75% of the cases are those normally found in the mouth and around the teeth, especially the oral anerobes, spirochetes, and fusiform bacilli. The remaining 25% show the more common pyogenic organisms. There seems to be a definite causal relationship between the oral anerobes and pulmonary suppuration. It is therefore probable that most lung abscesses follow the aspiration of these organisms into the lung, an occurrance that can easily take place under deep general anesthesia. This brings home forcibly the advantage of local anesthesia and careful oral hygiene as prophylactic measures against pulmonary suppuration.

Contrary to what one might expect, over half of the lung abscesses occur in the upper lobes of the lung; in some reports the incidence is two to one. More than half are found in the right lung. About three fourths of the abscesses are peripherally situated and in most of these cases the parietal and visceral pleural layers are adherent. This is very important in operative drainage of the abscess.

The most important factors in the diagnosis of lung abscess are history and x-ray. Physical examination and laboratory procedures are of less value.

The typical history is that some ten to fourteen days after an operation or in convalescence from bronchopneumonia, the patient rather suddenly complains of pain in the chest, and begins to run a septic type of temperature, sometimes with chills. At this time cough begins, and a few days later there is a profuse expectoration of foul pus. This expectoration may be so sudden and so large as to almost drown the patient in his own sputum. The disease is very debilitating and loss of weight and general malaise are generally quite marked. Clubbing of the fingers is a very frequent finding and often comes on within a week or two after the onset of the disease. Instead of the profuse foul sputum characteristic of rupture into a bronchus, there may be sudden shock and dyspnea from rupture into the pleural cavity and tension pneumothorax. This is an acute emergency and demands immediately aspiration or adequate drainage.

Physical examination will show dullness over the area involved by the abscess, but the auscultatory signs may vary all the way from those of consolidation to those of large cavities filled with fluid and air.

Sputum is usually foul in odor and purulent or mucopurulent in character. On standing it separates into three layers; mucus on top, saliva in the center, and pus at the bottom. The presence of elastic tissue fibers in the sputum is strongly suggestive of abscess. Leukocytosis in the blood varies, depending upon the acuteness of the condition. Tubercle bacilli should always be ruled out by careful study of smears from the sputum.

X-ray is the most important aid in diagnosis of lung abscess, since it not only tells us whether the abscess is present but also its location and extent. It is important to take lateral as well as anterior posterior views in order to locate the abscess with relation to the back or front of the chest wall. The distance from the abscess to the chest wall is of great value in locating the best place for surgical drainage.

Lung abscess can usually be diagnosed from the history and x-ray alone. There is no justification for aspiration through the chest wall as a diagnostic procedure. The bronchoscope is sometimes of value in locating the bronchus from which pus is coming and ascertaining whether or not there is a foreign body in the bronchus.

Prognosis in lung abscess should always be guarded. Complications, particularly abscess of the brain, are frequent and have a high mortality. An almost direct path can be traced from the left ventricle to the brain by way of the innominate and carotid arteries. This explains the high incidence of cerebral abscess complicating pulmonary suppuration.

Treatment can be divided for convenience into medical and surgical. This does not mean that the two should be sharply dissociated. On the contrary, in this disease, as in all problems in thoracic surgery it is essential that the internist, roentgenologist and surgeon work hand in hand.

Postural drainage should be tried in all cases unless the condition of the patient absolutely forbids it. This can best be done by elevating the foot of the bed to an angle of 45° three or more times a day. At first the patient should lie on each side for three to five minutes and gradually increase the time to thirty to forty-five minutes. He should lie on both sides no matter where the abscess is situated. If the abscess communicates with a bronchus, and most of them do, this allows the accumulated secretions to be evacuated. While there is no doubt that bronchoscopy is of utmost value in removing foreign bodies and washing out abscess cavities, it has yet to be shown that it is superior to postural drainage as a routine procedure.

In some cases where oral spirochetes and fusiform bacilli are found in the sputum, an intensive course of intravenous arsphenamine therapy will cause a dramatic disappearance of symptoms. Unfortunately it works in only a few cases.

Artificial pneumothorax is of value sometimes in centrally located abscesses where the pleural layers are not adherent and the abscess communicates with a bronchus. Practically complete collapse must be obtained and maintained for from three to five months. Routine use of pneumothorax for lung abscess is a dangerous procedure. Unless carefully done in selected cases it may easily cause rupture of the abscess into the pleural cavity or into the mediastinum.

The mortality from lung abscess treated with medical procedure alone ranges from 40 to 60%. The great danger in medical treatment is prolonging the treatment after surgery is indicated.

Indications for surgery in lung abscess are:

1. When improvement is not marked after 3 to 6 weeks of careful medical treatment with postural drainage.

2. In cavities with very thick walls early operation is indicated.

4. To remove foreign bodies in abscess cavities that cannot be reached with the bronchoscope.

5. If rupture into pleura or mediastinum occurs.

Surgery is most successful in peripherally located abscesses where the pleural layers are adherent. Operation is best done with local anesthesia, but gas-oxygen anesthesia can be used if necessary.

The incision is made diagonally across the ribs overlying the abscess and a portion of one rib resected subperiosteally. If the pleural layers are now seen to be adherent the operation can be continued. If the pleural layers are not adherent the pleura may be opened at this stage accidentally and collapse of the lung takes place. In this event the lung should be quickly palpated to locate the abscess and the lung then reinflated either by instructing the patient to strain or using positive pressure anesthesia. The wound in the pleura can be then closed with suture and packing. If the pleural layers are not adherent and the pleura is not opened accidentally, it is better to pack in iodoform gauze to promote adhesions, close the wound and finish the operation at a second stage about a week later. The pleural layers being now adherent, an aspirating needle is inserted directly into the lung and the abscess cavity located by aspirating air and pus. When the abscess cavity is located it can be opened into, either with the finger, electric knife, or scalpel. Enough of the outer abscess wall along with the overlying ribs and muscle should be removed to allow careful inspection of the whole abscess cavity for the presence of side pockets of pus. If these are found they should be connected with the main cavity. The danger lies not in making too large an opening into the abscess but in making too small a one that will later contract and hinder adequate drainage. The abscess cavity should be packed with strips of vaseline gauze or loose drains and the edges of the skin wound sutured loosely about the drains. Postoperatively, the wounds require frequent dressings and careful inspection of the abscess cavity. Patients may be up and about as soon as they recover from the immediate effects of the operation. Most cases will drain at least a month but in chronic cases it is essential to keep the drainage tract open for from three to six months or longer. In any event a small draining sinus is much to be preferred to a large putrid abscess.

The general mortality from surgical treatment runs around 20 to 40%. It is practically always much lower than that from medical treatment alone and this in spite of the fact that the cases that come to surgery are almost always cases that have not been benefited by medical treatment. In this disease, close cooperation be-

tween internist and surgeon is essential, and early diagnosis and early operation will give the best ultimate results.

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ACUTE AND CHRONIC DISEASES

An Appreciation of Thomas Sydenham's Book.

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DeLand.

It may seem as if one more paper on such a well-known and much-written-of personage as Sydenham were unnecessary, and perhaps it is, but at the present time with an increasing interest in medical history it seems well to recall him and some of the interesting aspects of his book. In dealing with by-gone men we are too apt to dwell on their lives and their chief fame to glory, forgetting and omitting much of their ordinary knowledge and activity. It is as true today as in 1809 when Rush wrote: "The works of Dr. Sydenham are singular, in being alike celebrated and neglected by modern physicians." We all pay homage to Dr. Sydenham, but not many of us have read his book, or even his more famous treatises such as the ones on the gout, rheumatism and erysipelas. His book is well worth reading, not only for pleasure, but for instruction, though we need not go as thoroughly into it as he would wish: "If a man will give them a single reading, I am sorry that I should be the means of making him lose his time, but if he will peruse them often and commit them to memory, I daresay he will reap such advantages from them as may in some measure equal my wish and the great pains I have been at, in making and compiling them." If, however, one would read the clinical history of the gout which has never been excelled, or the symptoms and signs of the venereal diseases described superbly or an excellent description of rheumatic fever and its various forms, then one should consult Sydenham. His descriptions are exceedingly accurate and detailed, and better, they are clear and lucid, written in an easy and serious style.

The preface to the book is perhaps the most revealing part of the book as far as helping us to understand his philosophy and theory of practice for the body of his work is almost wholly descriptive. "A disease," he says, "is no more than a vigorous effort of nature to throw off the morbific matter." How closely does modern pathological teaching echo this when it insists on the theory of tissue response to injury, and the corollary of this that nature is the cure is also emphasized by his statement: "Nature alone terminates distempers, and works a cure with the assistance of a few simple medicines, and sometimes even without any medicine at all." He understood the physician's role and decried against the cant and hypocrisy of his profession which sought to have itself considered superhuman and endowed with magical powers. As a result he insisted, persistently, pugnaciously and vehemently on observation, close observation of disease, both as it manifested itself and how it varied after treatment so as to arrive at a knowledge of the true history and constitution of the various illnesses that man can experience. His writings reveal that this was his crusade. In his answer to Dr. Robert Brady, Regius Professor of Physic at Cambridge, he writes in 1680: "For the lives of men are but too much trifled with: on the one hand by empirics, who are ignorant of the history of diseases, and the method of cure, and only provided with receipts; and on the other hand by such idle pretenders as rely wholly upon theory. . . . But that method of practice, and that only will relieve the patient, which deduces the indications of cure from the symptoms of diseases, and afterwards confirms them by experience." These thoughts are echoed in various of the treatises and in the preface, and though too often accompanied by protestations of Sydenham's humbleness and complete disinterest in the personal side of his crusade, yet we cannot doubt his sincerity. He was no less careful in the observation of his therapeutics and the results. He insisted that any treatment given should have some reasonable basis for its use and that the effects of a drug could only be known by close observation. The mere fact that a patient recovered was not for him reason enough to suppose that his medicine or regime had been the fault. "For the appearance or aspect of a disorder," writes Sydenham, "often varies according to the

different method of cure, some symptoms being rather occasioned by the physician than by the disorder itself." How true this is even today! How many symptoms are suggested by the physician and then relieved by suggestion as equally unintentional and the credit given overenthusiastically to some drug or pet prescription. He continues: "If any symptom, properly suiting their hypotheses, does in reality belong to the disease they are about to describe, they lay too much stress upon it, as if nothing more were wanting to confirm it, whereas, on the contrary, if it does not agree with their hypotheses, their manner is, either to take no notice at all of it, or but barely to mention it." How many by the pernicious use of barbiturates occasion symptoms which change the complexion of the disease picture or give us symptoms on which we base the diagnosis when the trouble in reality is something entirely different. Empiricism, lack of observation, a total inability to conceive of control experiments in the use of new drugs and techniques are not such strangers in our midst as to make Sydenham's pronouncements merely interesting historical reading. The lesson to be learned from this father of English medicine is that which has recently been so well taught by Blumer. Bedside diagnosis, close observation first before any interpretation or theorizing, is the essential lesson to be learned by the student before he can hope to become a clinician in the sense which that term has when applied to such men as Sydenham, Osler, Thayer, Rolleston and Blumer. Consider the keenness of Sydenham's observation when he says in his treatment of venereal diseases: "I do not depend much on injections into the urethra, because they ordinarily do much more mischief than service, either by their pungent acrimony or their stypticity; however, towards the declension a small quantity of rose water may be injected." He was always seeking to improve his therapeutics and realized that much of the medicine prescribed was of doubtful value. He considered that for each disease there was some particular remedy and it speaks for his advanced knowledge and intelligence that sought specifics. "It is nevertheless to be wished that the cure might be shortened by means of specifics (if any such medicines can be discovered) . . . the Peruvian bark being the only one we have." Only by observation can one interpret. This is the essence of Sydenham. It is to be regretted, perhaps, that he was not more inquisitive in searching for these specifics or developing new medicines, but we must remember that the spirit of research was not yet then developed far and that by nature Sydenham was an observer rather than an experimenter. He says: "And it is manifestly impossible that a physician should discover these causes that have not at least correspondence with the senses, so neither is it necessary," reflecting perhaps his disinclination to seek further than what could be seen on the surface. He does say that he has spent some years on "researches," but these researches were more to prove a preconceived notion, namely that medicines of plant origin were the best because minerals differed too much from the human and drugs derived from animals were likely to resemble human elements too much to be of value. He leaves us no data or conclusions so that it is only a matter of conjecture what these researches were.

The examination of one of his clinical histories is perhaps the clearest way of understanding the thoroughness and carefulness of his descriptions. It is to be remembered, of course, that these descriptions may not seem remarkable today but that they must be evaluated in their true light by imagining ourselves with him on his rounds. Picture yourself dressed in the grand style, no stethoscope, no light, no percussion experience, no ophthalmoscope, no knowledge of the history of the mosquito and the disease now called malaria. Indeed, the only instruments you possess are your finger tips, your eyes, ears and nose. Armed with these and your highest dignity you are allowed to go with Dr. Sydenham as he goes to see one of his patients suffering from the intermittent fever of the year 1661. His lecture heard at the bedside would be as he wrote it. "All intermittents, in general, begin with a chilness and shaking, which are soon followed by heat, and then by sweat. The patient usually vomits both in the cold and the hot fit, complains of great sickness, is thirsty, his tongue dry. And these symptoms abate in the same degrees as the sweat increases, which becoming more copious ends the fit. And now the patient continues tolerably well till the fit returns at the usual time; which in a quotidian happens once in the space of twenty-four hours, or a natural day; in a tertian every other day; and in a quartan, every third day, calculating from the beginning of one fit to the beginning of the next. But the two latter are frequently doubled, so that a tertian comes every day, and a quartan two days successively, the

third being the intermediate, or well day; and sometimes when it proves a triple quartan, it comes three days successively, the intermittent deriving its name from the manner of its first appearance." Can we improve this description in spite of our knowledge of the various phases in the life cycles of the various malarial parasites? Will anyone care to attempt a better description of pain than is found in the treatise on the gout? "The patient goes to bed, sleeps quietly until about two in the morning, when he is awakened by a pain, which usually seizes the great toe, but sometimes the heel, the calf of the leg, or the ancle. The pain resembles that of a dislocated bone, and is attended with a sensation as if water just warm were poured upon the membranes of the part affected." Such description, such careful history-taking has not often been seen even today when we have the five and ten page histories such as are seen at the Peter Bent Brigham and Johns Hopkins. It seems strange to me that with all the emphasis placed on the history as it is in the medical schools today more time isn't spent on teaching one to write a history. What better way of teaching such writing than by exposing the student thoroughly to the meticulous choice of words and uncanny sense of sequence of thoughts which Sydenham displays. Consciously Sydenham proclaims: "Observe." Unconsciously he shows us how to see what we do observe.

What then was Sydenham's philosophy? What was his guiding plan of life? From his medical writings we, of course, can gain no insight as to what he thought of his age, what life meant to him and what his relation to the mysterious infinity of nature was. Perhaps he had no deep philosophy as this, but we do know that he was suspicious of philosophy and philosophical systems. He says: "But though all hypotheses founded in philosophical reasonings are quite useless, since no man is possessed of intuitive knowledge, so as to be able to lay down principles as he may immediately build upon, yet when they result from facts and those observations only which practical and natural phenomena afford, they will remain fixed and unshaken." One may argue with Sydenham, as would Bertrand Russell, as to what constitute facts, and is knowledge built on fact after all any more definite than intuitive knowledge, but we can at least understand the purpose of the whole book and the main current of Sydenham's daily thinking by means of this passage. Sydenham wanted facts. In a day when new facts were being discovered and the falsity of life and living shown more glaringly with each discovery, he stood out and cried for facts. He insisted that one couldn't treat a disease until one knew by fact what constituted that disease, and similarly he must have felt that all of life should first be defined by fact before one could live without feeling oneself in a false position. He cried out against idle speculation in a day when idle speculation for the pleasure of speculation was not only the fashion but also the authority of things temporal, that is, factual. He protests thus: "There is likewise a kind of men, who out of vain affectation to pass for persons of superior understanding, plague the world with speculations that do not in the least contribute toward the cure of diseases, but rather tend to mislead the physician than to direct him. . . . Whence, though a man may become as wise as his state will allow, yet no one will attain to be a philosopher, at least in the degree that great name imports." Sydenham is a crusader; his desire is to improve knowledge, the medical knowledge of his time. He is a vehement crusader, as his book shows to anyone who will read it thoroughly. He is as vociferous if not as continuous as Carlyle in urging us to rid our minds of cant. Observation and interpretation on that observation only is truth. This it seems to me is the purpose of Thomas Sydenham's book.

Sydenham was not a genius. He was not remarkable for intellectual or philosophical attainments. He discovered nothing new. He invented no microscopes, stethoscopes, sphygmomanometers. He made no discoveries of the human body by dissection. He developed no new concepts as asepsis by studies of fermentation; he made no attempts to seek for the causes of disease, yet he remains one of the great figures of medicine. Why is this so? What has he left us that should make him so remarkable? Is the mere fact that he left a book full of clear descriptions of the ills man is heir to sufficient reason for his exaltation? The answer lies in his having left us method. No one has ever surpassed him in the methodical, careful and complete picturing of disease which depended on the close observation both of the patient and his story. This then is the great secret of Sydenham's fame. He left to the future the secret of bedside diagnosis. He maintained his intellectual honesty over vanity and the acrimony of his contemporaries, and only

by maintaining intellectual honesty can a method be developed. So let us close with his own definition of his method. "But all the philosophy of a physician consists in searching into the history of diseases, and applying such remedies as experience shows to be curative thereof; observing, as I mentioned elsewhere, the method of cure, which right reason, founded on the trite and natural way of thinking, and not vain speculation, points out."

THE BLACK WIDOW SPIDER

Frank T. Barker, M.D.,
Tampa.

The object of this paper is to create more interest in a subject about which very little is known generally. Although the author has seen four cases of Black Widow spider bite, credit for the bulk of scientific observations and facts herein contained must of necessity go to earlier and more experienced observers. Among human beings the bite of the Black Widow spider is an element of increasing danger, well worthy of earnest consideration and study.

Bogen reports seventeen deaths from among 380 cases, a mortality rate of four and one-half per cent. Others, however, claim the mortality rate to be lower.

The Black Widow spider, or Lactrodectus Mactans, sometimes called the "Shoe-button" spider, is found in all parts of the United States but prefers the southern climate. It is probably the only poisonous spider in this country. The female of the species is about one-half inch in length and has a black, shiny body, almost metallic in appearance. There is a small, hour-glass shaped marking on the under surface which varies in color, according to age, from yellow to deep red or scarlet. The male is smaller, of lighter color, with white stripes on the body, and is harmless. When his function is performed he is eaten by the female. After the female has hatched her brood she promptly dies and her body juices serve as food for her young which may number from 50 to 500. However, it is unusual for more than a very few of these to reach maturity as the majority are devoured by their brothers and sisters.

The web of the Black Widow spider consists of straggly, uneven, coarse viscous threads running in all directions, in all three dimensions, with none of the geometric exactitude or beauty of the webs of harmless spiders. This is perhaps due to the fact that the web is used mostly as a support for the spiders. The author has observed these spiders making use of a strand of the web as a means of transportation in the following manner. With one end of the strand attached to a limb of a bush the spider suspended at the free end is swung in the breeze until contact is made with some nearby object. The chief use of this sticky, viscous web substance, however, is for the purpose of entangling the spider's victim prior to devouring it. In doing this the Black Widow skirts its insect victim several times while constantly throwing out strands of web until the insect becomes helplessly enmeshed. Then comes the almost instantly fatal bite which is followed by the sucking out of the tissue juices.

The Black Widow may be found in any place or part of fields and wooded sections, but what chiefly concerns us is that in and around human habitations it is usually found in dark corners of sheds, barns, garages, and outdoor privies. Approximately half of the bites reported have occurred in privies and usually the bites occur at night and naturally more frequently it occurs in males. Of the four cases seen by the author two were bitten at night and two in daytime. The bites occurred on the hand, the buttock, the foot, and the toe.

The venom apparatus consists of a pair of glands situated one on each side of the anterior part of the cephalo-thorax, from each of which a duct leads to a small opening near the tip of the chelicera of the same side. This opening is so placed that it is not closed by the pressure of the bite, but allows the venom to flow into the wound. It is an oily, translucent, lemon-yellow liquid having an acid reaction and a hot bitter taste. It is a non-hemolytic protein poison which primarily affects the peripheral nerves.

The venom is even more toxic than that of the poisonous snakes and, in many ways, the symptoms of spider poison resemble those produced by the venom of poisonous snakes. The marked effect on the nervous system produced by the bite of the Black Widow indicates that the venom of these insects resembles that of the cobra more nearly than the venom of the rattlesnake or moccasin.

It is believed that all parts of the spider contain a toxalbumen which is mixed with the secretion of the poison gland, that the secretion from the poison gland produces only local symptoms, while the general symptoms are due to the presence of this toxalbumen. It is because of this

toxalbumen that the bite of the Black Widow is so severe as to occasionally cause death in human beings. It contains an hemolysin called arachnolysin which causes a destruction of the red blood cells of human beings, rabbits, and mice, but does not affect the red blood cells of horses, dogs, sheep, and guinea pigs. Some authors question whether the nervous symptoms following spider bite may not be due to changes in the blood rather than to a direct toxic effect on the nerve tissue.

Some very interesting experiments upon both small animals and human beings have been conducted. The macerated glands of one female spider have been mixed with ten drops of distilled water and injected into a cat subcutaneously. In about five minutes a series of clonic convulsions set in, quickly followed by tonic spasms and death within ten minutes. A quantity of eggs of the Black Widow spider were macerated and mixed with ten cubic centimeters of water which, when injected subcutaneously caused the death of a cat in three minutes. A rabbit died as a result of the same experiment in two and one-half minutes. One experimenter took a quantity of powdered virus prepared from macerated glands of the spider and experienced a chain of symptoms identical with that of the bite of the insect.

The American Indians rank the bite of the Black Widow spider with that of the rattlesnake. The method used in poisoning their arrows was to rub the tip of the arrow in the body juices of a macerated Black Widow spider.

The diagnosis of arachnidism depends upon:

1. History of exposure to, or actual experience of, the bite. There is usually no visible lesion at site of bite.

2. Pain, starting usually at site of bite, and extending to the larger muscles, particularly of the abdomen and chest. The pain is excruciating and agonizing, and is usually continuous. The victim writhes and groans constantly.

3. Respirations are shallow and labored.

4. There is a board-like rigidity of the abdominal muscles. Rigidity may be noted in the intercostal muscles, muscles of the back and in the leg muscles. Due to the abdominal rigidity, spider bite must be differentiated from acute surgical conditions of the abdomen.

5. An increase of from twenty to forty mm. in the blood pressure, hyperactive reflexes, and increased intraspinal pressure, are usually noted.

6. Increased body temperature, slow pulse, and a polymorphonuclear leukocytosis are noted.

7. Profuse perspiration, restlessness and anxiety, tossing in agony, nausea and vomiting, priapism and urinary retention are often seen.

8. Edema of the eyelids is one of the most pronounced and characteristic signs.

9. Constipation is always present.

10. Cyanosis, delirium, prostration or shock, insomnia, disturbance of speech, paralysis, convulsions, a macular skin eruption, chills, vertigo and jaundice may occur.

The acute symptoms last from a few hours to a few days but marked general muscular weakness and extreme nervousness usually persists for weeks after the bite. Shooting pains through the body and pelvis are also present. Many cases have been known to require from six to eight months to fully recover.

Treatment. In considering the treatment the most important phase is, of course, preventive. Efforts to rid the community of this insect by destroying the web, killing the spiders, etc., should be resorted to since treatment of the bite is mostly palliative. Large doses of morphine give remarkably little relief. Powerful sedatives and hypnotics are indicated. Hot compresses and hot baths give some relief. Spinal puncture is recommended as the most positive way of giving immediate and real relief. Intravenous injections of a ten per cent solution of magnesium sulphate have been known to help. Convalescent serum has consistently given substantial relief if injected almost immediately. Sodium amytal intravenously (15 gr.) produces complete muscular relaxation and sleep. This of course lasts only for eighteen or twenty hours, when the dose should be repeated.

Spider bite poisoning is a self-limited condition and usually clears up in a few days or weeks. However, it is too often fatal. It is probable that a small percentage of the deaths reported have been due to injudicious treatment. There is no indication for stimulants such as caffeine, strychnine, alcohol, and adrenalin. There is seldom any indication for local treatment, other than hot compresses, due to the fact that the venom is so rapidly absorbed. However, if seen early, tincture of iodine may be applied to the skin at the site of the bite.

An antivenin prepared from the blood of sheep is used extensively in Brazil and is giving excellent results. In Americ an antivenin prepared from the blood of rats is being used.

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John S. Helms, Jr., M.D. *Tampa*
W. C. Payne, M.D. *Pensacola*
Warren Quillian, M.D. *Coral Gables*

COMMITTEE ON PUBLICATION

Walter C. Jones, M.D., Chairman *Miami*
Shaler Richardson, M.D. *Jacksonville*
Herbert E. White, M.D. *St. Augustine*

OUR NEXT STATE MEETING

A Big Boat—A Big Crowd—A Big Time

As a result of the selection by the House of Delegates at our State Medical Meeting, we are to meet next year aboard ship. We are sailing from Miami aboard the palatial Steamship Florida of the P. & O. Steamship Company and cruising around in the beautiful waters of the Bahama Island region, spending a half day ashore in Havana. The ship is ideal for such a meeting with all outside state rooms, spacious decks, beautiful lounges, ample convention space, equipped with loud speakers, and all of the other conveniences and attractions afforded by the best hotels. There will be plenty of time for business and scientific meetings and ample opportunity for amusements. There will be card games, music by an orchestra, teas, deck games, treasure hunts, etc., for those of our wives who enjoy them and, for those who do not, a wonderful opportunity to lounge in comfortable deck chairs, knit, crochet, watch the flying fish, and chatter. There will be deep-sea fishing, deck games and golf in Havana for the men.

The plan is to leave Miami at 7:00 p. m., have supper aboard ship, remain out for three nights and two days, and to arrive in Miami on the morning of the third day with breakfast aboard ship. Provisions will be made to take your car at the dock in Miami, store it and deliver it to you at the dock on your return.

Last, but not least, this grand trip is to cost only $32.50 per person for boat fare which will include everything on the boat—that is—*nearly everything.* Of course, if you must take along more money, the bar will be open and a chute will be connected with the storage so that any party assembled in the bar will have no trouble in disposing of any of their number who might become boisterous.

PLAN NOW TO BE THERE

PLAN NOW TO BRING YOUR WIFE

Let's All Become Better Acquainted and Better Friends. Aboard Ship Is a Fine Place to Accomplish This.

Announcements by the Committee on Arrangements and advertisements by the Steamship Company, showing pictures of the boat and plans of accommodations, appear in this Journal. Be sure to look them over.

LAY MEDICAL EDUCATION

For a number of years there have appeared every day in the daily papers articles written by doctors, supposedly for the purpose of informing the layman on medical subjects. While for the most part these writings deal with simple subjects and are fairly understandable to the average intelligent Doctor of Medicine and a very limited number of laymen, the fact remains that a considerable number of them deal with material that is yet in the experimental stage, or is of questionable accuracy.

The layman, whether it be out of idle curiosity or for purposes of self-diagnosis, is thirsty for information pertaining to Medicine or its allies and is consequently extremely gullible. He, however, does not possess the fundamental knowledge of anatomy, physiology and so forth which is a prerequisite to intelligent thought on, or interpretation of, any scientific medical subject. He, therefore, most frequently misinterprets the statements, whether they be established facts or not and is either left in a state of mental quandary over the matter or is convinced that the condition described is just exactly like his, a state that encourages self-medication.

There is no possible way to educate the layman in matters medical without first teaching him the fundamentals that it took you doctors years to learn, never to master. The layman should not be educated in medical matters but should be encouraged to seek the counsel of his medical advisor and be governed accordingly.

GRADUATE SHORT COURSE FOR DOCTORS OF MEDICINE IN FLORIDA JUNE 24-29, 1935

ADMINISTRATIVE OFFICERS

John J. Tigert, President, University of Florida.
B. C. Riley, Dean, General Extension Division.
Herbert L. Bryans, President Florida Medical Association.
Homer L. Pearson, Past President, Florida Medical Association.
Shaler Richardson, Secretary-Treasurer, Florida Medical Association.
W. K. Mitchell, Secretary, Institutes and Short Courses, General Extension Division.

COMMITTEE REPRESENTING THE FLORIDA MEDICAL ASSOCIATION

Dr. T. Z. Cason, Jacksonville, Chairman.
Dr. G. C. Tillman, Gainesville, University Physician.
Dr. W. H. Spiers, Orlando.
Dr. Warren Quillian, Coral Gables.

General Information

The Graduate Short Course for Doctors of Medicine in Florida will be held at the University of Florida June 24-29. This is the third annual course conducted by the General Extension Division in cooperation with the Florida Medical Association. The program of instruction was arranged by a committee of doctors appointed by the President of the Florida Medical Association. The purpose of the Course is to give the doctors of Florida an opportunity to keep up with the latest discoveries in the field of medical science through direct contact with leading specialists of the country.

REGISTRATION

The committee representing the Florida Medical Association will collect a registration fee of $5. This is the only expense in connection with the course. It is requested that the fee accompany the registration and that all doctors who expect to attend the Short Course register in advance in order that adequate accommodations may be arranged.

OTHER EXPENSE

Special rates will be made by the Gainesville hotels. Lodging may be secured near the University campus for $1 per day. The University cafeteria will serve meals for $.80 per day.

INFORMATION DESK

The information desk will be situated in the lobby of the P. K. Yonge Laboratory School. Immediately upon arrival in Gainesville, doctors are requested to report to the information desk where instructions for the week will be given.

LABORATORY AND EXHIBITS

The Florida State Board of Health will set up a model laboratory and give instruction on laboratory technique. There will be exhibits by the Florida Radiological Association on Roentgenology and the Florida Tuberculosis and Health Association on Tuberculosis. Exhibits will be in charge of specialists throughout the week. Two recess periods in each day's program have been set aside during which the doctors may visit the exhibits and enjoy recreation.

CHANGE IN FACULTY AT SHORT COURSE

Dr. Arthur M. Shipley, who was originally announced as the teacher of the course in Surgery at the Graduate Short Course, has found it impossible to be present. At his suggestion the committee invited Dr. Charles Reid Edwards, Professor of Clinical Surgery at the University of Maryland, to present the course. In recommending Dr. Edwards, Dr. Shipley wrote as follows:

"He . . . is a seasoned operator and an excellent teacher. He is interested in all phases of general surgery, but has been paying special attention to the use of radium in cancer. He is a member of the Southern Surgical and of the Society of Clinical Surgery. He went through all stages of the house officer staff in the University Hospital after his graduation, saw service in France with the Twenty-Ninth Division and was in charge of a team working in an advanced hospital. He is Chief Surgeon of the Western Electric Company in Baltimore and does about as much teaching in the Surgical Department of the University of Maryland as I do."

PROGRAM OF GRADUATE SHORT COURSE, JUNE 24-29, 1935

Hours	Monday, June 24	Tuesday, June 25	Wednesday, June 26	Thursday, June 27	Friday, June 28	Saturday June 29
9:00-10:00	Pediatrics Casparis	Medicine Bethea	Pediatrics Casparis	Gynecology Novak	Gynecology Novak	Surgery Edwards
10:00-11:00	Obstetrics Adair	Obstetrics Adair	Obstetrics Adair	Surgery Edwards	Surgery Edwards	Gynecology Novak
11:00-11:30	Recess	Recess	Recess	Recess	Recess	11:00-12:00 Orthopedic Surgery Campbell
11:30-12:30	Medicine Bethea	Pediatrics Casparis	Medicine Bethea	Orthopedic Surgery Campbell	Orthopedic Surgery Campbell	
12:30- 2:00 Lunch hour Round-table Discussion	Chairman: Casparis	Chairman: Bethea	Chairman: Adair	Chairman: Edwards	Chairman: Novak	12:00- 1:00 Surgery Edwards
2:00- 3:00	Obstetrics Adair	Obstetrics Adair	Venereal Diseases Wenger	Gynecology Novak	Surgery Edwards	
3:00- 3:15	Recess	Recess	Recess	Recess	Recess	
3:15- 4:15	Medicine Bethea	Pediatrics Casparis	Medicine Bethea	Surgery Edwards	Gynecology Novak	
4:15- 5:15	Pediatrics Casparis	Medicine Bethea	Obstetrics Adair	Venereal Diseases Wenger	Venereal Diseases Wenger	
8:00-		Alachua Co. Medical Soc. Smoker: Symposium, Malaria		Lecture on Social Diseases Wenger		

EVENING MEETINGS AT SHORT COURSE

During the week of the Short Course, two evening meetings have been arranged which are considered of value. On Tuesday evening, at eight o'clock, the Alachua County Medical Society has scheduled a smoker which will be followed by a symposium on "Malaria." Dr. Mark F. Boyd, Rockefeller Foundation research worker stationed at Tallahassee, will open the program with a paper on the etiology of the disease. He will be followed by Dr. T. H. D. Griffitts, of the United States Public Health Service, who will speak on the distribution of malaria in Florida. Dr. O. W. Bethea of Tulane University, who will be presenting the course in Medicine at the Short Course, will have the final paper, discussing the treatment of malaria. Following the presentation of the papers there will be a round table discussion of malaria in all its aspects, in which all present will be asked to participate.

On Thursday evening, Dr. O. C. Wenger, Medical Officer in Charge, Hot Springs National Park, will lecture on "Venereal Diseases." This meeting will be open to the general public and Dr. Wenger's paper will be planned with this in mind.

BIOGRAPHICAL SKETCHES OF PHYSICIANS GIVING SHORT COURSE

Dr. Horton Casparis

Dr. Horton Casparis, Professor of Pediatrics at Vanderbilt University Medical School, is returning this June to present the course in pediatrics. Dr. Casparis will be remembered as the lecturer in this subject last year. Dr. Casparis received his A. B. degree from the University of Texas and his M. D. degree from Johns Hopkins Medical School, where he spent five years on the pediatric service following his graduation. After a year in the clinics of Europe he went to Vanderbilt University as head of the Department of Pediatrics.

Dr. Casparis' especial interest has been tuberculosis for the past fifteen years. He has talked on the subject in many sections of the United States. He has taken an active part in helping groups in various sections of the country, chiefly the South, organize their work in the prevention and control of tuberculosis. He is a consultant in all of the work done in Tennessee by the State Health Department and by the Tennessee Tuberculosis Association.

Dr. Charles Reid Edwards

Dr. Charles Reid Edwards of Baltimore, who will present the lectures in Surgery at the Short Course, graduated from the University of Maryland in 1913. From June, 1917, to June, 1919, he served in the United States Army.

Specializing in general surgery and radium therapy, Dr. Edwards is on the staff of the University Hospital, Union Memorial Hospital, Church Home and Infirmary Hospital, and Woman's Hospital. He is Professor of Clinical Surgery at the University of Maryland.

Dr. Edwards is a member of the Southern Surgical Association, the Society of Clinical Surgery, and the American College of Surgeons.

Dr. Fred Lyman Adair

Dr. Fred Lyman Adair, chairman of the Department of Obstetrics and Gynecology and Chief of Service at the Chicago Lying-in Hospital at the University of Chicago, will give the course in obstetrics at the Third Annual Short Course for Doctors of Medicine, to be held in Gainesville, June 24-29. Dr. Adair was born in Anamosa, Iowa, where his father was a practicing physician. He received his B. S. and M. A. degrees from the University of Minnesota and his M. D. degree from Rush Medical School, 1901. Following his internship at Michael Reese Hospital, Chicago, he carried on a general practice in Minneapolis until 1908, when he took graduate work at Charité Hospital, Berlin, Germany. Since that time he has specialized in obstetrics and gynecology. From 1905 to 1929 he was Professor of Obstetrics and Gynecology at the University of Minnesota. In 1929 he left Minnesota to go to Chicago Lying-in Hospital as Professor of Obstetrics and Gynecology. He was made Chairman of the Department of Obstetrics and Gynecology and Chief of Service at the Chicago Lying-in Hospital in 1931. He served as Chief of Obstetrics and Gynecology Service of Minneapolis General Hospital, Asbury Methodist Hospital, and Swedish Hospital.

Dr. Adair served one year in the World War with the American Red Cross in France and Belgium. He was instrumental in establishing prenatal work in Paris and in establishing the Service Medical Social de Maternite in Paris.

Dr. Adair is a member of the following organizations: Delta Upsilon; Nu Sigma Nu; Sigma Xi; Minneapolis Academy of Medicine; American Medical Association; American College of Sugeons; American Association of Obstetricians, Gynecologists, and Abdominal Surgeons; Obstetrics Advisory Committee Children's Bureau U. S. Department of Labor; Editorial Committee American Journal Obstetrics and Gynecology; Chicago Medical Society; Chicago Gynecological Society; University Club of Chicago; Olympia Fields Country Club; Past President, Chicago Gynecological Society; Former Treasurer, American Gynecological Society; Former President and member Hennepin County Medical Society, Minneapolis, Minnesota; Former Secretary and Chairman, Section of Obstetrics, Gynecology, and Abdominal Surgery, American Medical Association; Former Chairman, Committee on Prenatal Maternal Care, White House Conference on Child Health and Protection.

Vice President, American Board of Obstetrics and Gynecology; President, American Gynecology Club; Chairman, American Committee on Maternal Welfare; Chairman, National Committee on Federal and State Legislation on Birth Control.

He is the author of numerous articles dealing chiefly with obstetrics and gynecology in various medical journals and co-author of "Obstetric Medicine" with Dr. E. J. Stieglitz.

REPORT OF COMMITTEE ON TUBERCULOSIS AND PUBLIC HEALTH

Your Committee on Tuberculosis and Public Health, appointed May 17, 1934, has held two meetings in person and two by mail.

The Committee has:

(1) Sponsored tuberculosis exhibits at the Graduate Short Course for Physicians, University of Florida, June 25-30, 1934. This exhibit included:
 - (a) Latest periodicals, pamphlets and publications on tuberculosis.
 - (b) P.P.D.—new standardized product for tuberculin testing—sponsored by the Committee on Medical Research of the National Tuberculosis Association, the United States Public Health Service and others.
 - (c) Tuberculin Testing Demonstrations.
 - (d) X-ray Films demonstrating various tuberculous conditions.
 - (e) Pneumothorax Demonstration.

(2) Sponsored a similar exhibit at Seventh Annual Conference of the Florida Tuberculosis and Health Association, Orlando, April 2 and 3.

(3) Assisted in bringing to Florida Dr. J. Arthur Myers, of Minneapolis, Medical Director, Lymanhurst School and member of editorial boards of the American Review of Tuberculosis and Journal-Lancet, to address medical and semi-lay groups.

(4) Increased from 400 to approximately 800 the list of Florida physicians receiving tuberculosis abstracts, a resumé of test papers on tuberculosis as a courtesy of the Florida Tuberculosis and Health Association.

(5) Acted as technical advisors for the Florida Tuberculosis Board (appointed by Governor Sholtz May 1, 1934).

(6) Acted as technical advisors for and passed upon material to be distributed by the Florida Tuberculosis and Health Association to medical, lay and semi-lay groups. Rejected as not desirable one pamphlet on cost of medical care.

(7) Recommended a Tuberculosis Committee for the Florida State Medical, Dental and Pharmaceutical Association (Negro medical association.)

(8) Given pneumothorax and tuberculin testing demonstrations at tuberculosis institutes for nurses sponsored by the Florida Tuberculosis and Health Association.

(9) Arranged for speakers on programs of local medical societies and tuberculosis associations.

In addition, the chairman of this committee has acted as official representative of the Medical Association on the Board of the Florida Tuberculosis and Health Association and as advisor to the Board and Executive Committee, and the Committee:

1. Is working out with educators and pediatricians a plan for a school health education program to be submitted for approval to the Florida Medical Association.
2. Making preparations for a pathological exhibit on tuberculosis to be used before semi-lay groups.

Respectfully submitted,

M. Jay Flipse, Chairman;
Arnold S. Anderson,
William C. Blake,
T. Z. Cason,
J. Maxey Dell.

(Editor's Note: The above report from the Committee on Tuberculosis and Public Health was not read before the First General Session at the Annual Meeting of the Association, held in Ocala in May. The Committee report has just been received with the request that it be published in the Journal).

PROCEEDINGS OF SIXTEENTH ANNUAL MEETING FLORIDA RAILWAY SURGEONS' ASSOCIATION,

Ocala, May 13, 1935

The Sixteenth Annual Meeting of the Florida Railway Surgeons' Association convened in the Dixie Theatre, Ocala, at 10:30 a. m., May 13, 1935. After the Roll Call, the Minutes of the last meeting were read. This was followed by Committee Reports and the Address of the President, Dr. Walter C. Page of Cocoa.

At 12:00 o'clock, a luncheon meeting was held in the main dining room of the Marion Hotel.

The scientific program was held at 1:30 p. m. in the Dixie Theatre. The following papers were read and discussed.

"Organized Labor and Railway Medicine", V. A. Lockwood, St. Augustine.

"Treatment of Acute Injuries with Reference to Fractures", T. H. Bates, Lake City.

"Where the Field of the Oculist Meets That of the Practitioner", B. F. Hodsdon, Miami.

"The Handling of Brain Injuries", J. Maxey Dell, Jr., Gainesville.

"Surgical Errors", C. D. Christ, Orlando.

At 3:30 p. m., a business meeting was held. The president-elect, Dr. Leland F. Carlton of Tampa was inducted into office. The election of officers for the coming year was then held, which resulted as follows:

President—Leland F. Carlton, Tampa.

President-elect—T. M. McDuffee, Manatee.

Vice-President—J. Ralston Wells, Daytona Beach.

Secretary-Treasurer—H. D. Clark, Ft. Pierce.

* * *

The following committees have been appointed to serve the Florida Railway Surgeons' Association for the coming year:

Executive—
J. W. Alsobrook, Chairman, Plant City.
H. C. Dozier, Ocala.
T. W. Hutson, Miami.

Scientific—
A. R. Beyer, Chairman, Tampa.
Hugh West, DeLand.
H. A. Walker, Miami Beach.

Necrology—
Hubbard Gates, Chairman, Bradenton.
J. A. Strickland, St. Petersburg.
W. E. VanLandingham, West Palm Beach.

STATE NEWS ITEMS

Another high honor has come to a Florida doctor with the election of Dr. H. Marshall Taylor of Jacksonville to the presidency of the American Bronchoscopic Society at the annual convention of that organization in Toronto, Ontario, Canada.

This is the first time a Southern man has ever been accorded the distinction of heading the society, which was founded in 1917. Dr. Taylor was a vice president during the past year.

* * *

Preliminary information relative to next year's annual meeting, planned to be on board ship, will be found in this Journal on the editorial page and also among the advertisements in the back.

DR. JOHN A. B. SINCLAIR

On May 19th, 1935, Dr. John A. B. Sinclair succumbed to a myocardial condition while a patient at the St. Francis Hospital, Miami Beach. Dr. Sinclair was 56 years of age. He had been practicing medicine in Miami for the past twelve years. He was a member of the Dade County Medical Society, and the American Medical Association. He was Medical Examiner for the Opalocka Naval Air Base and the Veterans' Administration, Bay Pines, Fla.

While being a very active man in his profession, he was both an adventurer and a naturalist. As an adventurer there were many occasions which required marked courage and great strength. As a naturalist he often shared studies of field work with Dr. David Fairchild and Dr. John Gifford and other authorities interested in tree life.

Dr. Sinclair had a very brilliant mind. He was educated in Charlottesville, Virginia, and after graduating from the State University there became the youngest professor that institution has ever had, teaching Anatomy at the age of nineteen. He took his medical degree at Johns Hopkins, and served his internship at Bellevue Hospital, New York, returning to Charlottesville where he practiced until 1908 when he received a commission as a medical officer in the United States Navy. He was first stationed with the Navy in Alaska as head of the Naval Hospital at Sitka. During the World War he served as medical officer on the transports Von Steuben and Zeelandia. He made seventeen crossings to France and attained the rank of Lieutenant Commander. At the close of the War he was again returned to Alaska where he was in charge of the hospital in Chicagof. In 1923 he moved to Miami and had been in active practice since that time.

Dr. Sinclair, in addition to his medical post here, was vice-president of the Miami Aero Club, a member of the Army and Navy Club and the Harvey Seeds Post, American Legion.

He is survived by his mother, Jean F. Sinclair; three daughters, Mrs. J. Sinclair Shafer, Mrs. Shannie Holloway of New York, Miss Glenna Sinclair of Miami; a son, Robert Upton Sinclair; two grandchildren, two brothers, and four sisters.

COMPONENT COUNTY SOCIETIES

DADE COUNTY MEDICAL SOCIETY

At the meeting of the Dade County Medical Society held June 7 in the Huntington Club Rooms, Miami, the scientific program consisted of a case report presented by Dr. Walter C. Jones, Jr., and a paper by Dr. Marvin Smith, entitled "Partial Stomach Resection After the Method Advocated and Practiced by Professor Finsterer of Vienna."

DUVAL COUNTY MEDICAL SOCIETY

The regular meeting of the Duval County Medical Society was held at the George Washington Hotel, Tuesday, June 4. At this meeting, Dr. W. McL. Shaw was named president-elect of the Society. Doctor Shaw will take over his duties as president in January.

The Society went on record as approving the offer of the Jacksonville Bar Association to have its members present at the polling places in the city and county for the special election on the proposed city-county consolidation, held June 18.

MONROE COUNTY MEDICAL SOCIETY

THE MONROE COUNTY MEDICAL SOCIETY HAS BECOME THE FOURTEENTH SOCIETY TO PAY 100% OF MEMBERSHIP DUES FOR 1935. THE OFFICERS OF THIS SOCIETY ARE:

President—HARRY C. GALEY.
Vice-President—NILO C. PINTADO.
Sec'y-Treasurer—WILLIAM R. WARREN.

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ADVERTISERS' NOTES

The Treatment of Wounds

A modern writer on surgical matters has recently remarked that it is impossible to discuss the non-opperative treatment of wounds without acknowledging the fundamental importance of proper preliminary surgical treatment. The application of an antiseptic may be considered as supplementary to asepsis, operative cleansing of wounds, with removal of foreign bodies, excision of traumatized tissue, and establishment of proper drainage.

For topical application an antiseptic should be used which will not destroy viable cells. The antiseptic should permit of frequent application, without danger of systemic action. It should so cover the intact epidermis surrounding the wound as to exclude these areas as possible sources of reinfection.

Merthiolate, Lilly, will, it is claimed, capably fulfill the specifications for the antiseptic as here outlined.

Merthiolate Solution, 1:1,000, is an aqueous, stabilized, isotonic dilution which is stainless (No. 45). Merthiolate Tincture, 1:1,000, is an alcohol-acetone-aqueous solution which contains a harmless coloring matter and delineates treated areas (No. 99). Merthiolate Tincture and Solution are supplied in four-ounce and pint bottles.

Merthiolate Ointment, 1:2,000, is supplied in one-ounce tubes and pound jars (No. 59); Merthiolate Ophthalmic Ointment, 1:5,000, in one-dram tubes (No. 31); Merthiolate Cream, 1:1,000, in one-ounce tubes; and Merthiolate Jelly, 1:1,000, in half-ounce tubes.

Abstract—Philip Morris Co.

Flinn, Frederick B.—Some Clinical Observations on the Influence of Certain Hygroscopic Agents in Cigarettes. Laryngoscope, 1935, XLV No. 2, 149-154. Mulinos & Osborne (Proc. Soc. Exper. Biol. and Med. 32: 241-245, 1934) using rabbits showed the edema caused by cigarettes using diethylene glycol as hygroscopic agent to be less than that from cigarettes using glycerine. Flinn reports a number of clinical observations. In cases showing congestion of some portion of the mucous membrane of upper respiratory tract as result of smoking glycerine treated cigarettes, on smoking cigarettes containing diethylene gly-

col, congestion disappeared in 62.3 per cent and considerable improvement noted in other 37.7 per cent. On returning to glycerine treated cigarettes 80 per cent showed a return to the congested condition of the pharynx and larynx. Coughs and irritation of the tongue showed analogous results. "Summary: The combustion products of glycerine when it is used as a hygroscopic agent in cigarettes will under certain conditions cause an irritation of the throat. The combustion products of diethylene glycol cause only a slight irritation, if any, of the throat. There is some evidence that they may be beneficial where irritation is present."

Ivy and Oak Poison

Poison Ivy and Poison Oak Season is usually at its height from May to November. Many more cases of ivy and oak poison occur during the summer because persons go into the country and are thus exposed to the disturbance although many cases of poison ivy occur during fall and winter months due to handling of fire wood on which the roots and tendrils of poison ivy are collected on the bark of the wood.

Rhus Tox Antigen (*Poison Ivy Antigen*), *Rhus Venenata Antigen* (*Poison Oak Antigen*), offer specific cures for the treatment of persons afflicted with these most distressing irritations causing dermatitis venenata.

In the Eastern and Middle States Poison Ivy from Rhus toxicodendron causes over 90 per cent of the dermatitis. In Rocky Mountain and Pacific Coast States the reverse ratio holds true for Poison Oak (Rhus venenata, Rhus diversiloba) and for that reason the two antigens are not combined.

No ointment of a greasy base should be used as a local application in the treatment of dermatitis venenata because grease or oils dissolve the toxicodendric acid and increases the dermatitis. A good routine in treatment, after injecting the Antigen, is to scrub the affected area with alcohol, providing the skin is not broken, wash with castile soap and water, dry the parts then apply a stearate base ointment, containing benzocaine, phenol, camphor and boric acid, for routine local treatment.

Rhus Tox and Rhus Venenata Antigens for the cure (desensitization) of ivy and oak poisons are 40% alcoholic solutions of the *antigenic principles* to which is added procaine to make 0.4 per cent strength; this, together with refinement in processes, minimizes smarting and pain of injection.

Antigens in oil solutions are to be avoided because the unabsorbed oil causes marked local tissue change which may bring about tumefaction or even malignant complications. Jorstad and Glenn, *Journal Amer. Med. Asso.*, Jan. 7, 1928. *The Medical Times*. June—1928, 23.

Dosage

The Antigens should be injected deep intramuscularly. Intramuscular injections lessen irritation and are quickly absorbed. *Do not massage injected area after injection of the Antigen. Superficial injections will cause local reactions with a localized dermatitis.*

First dose ½ to 1 cc. of the Antigen; *second and subsequent doses* 1 cc. of the Antigen at 12 to 24 hour intervals.

For Complete Treatment four injections of the specific Antigen are advised even though the dermatitis is brought under control after the first or second injection. This procedure may give protection to the patient for the season and prevent, or at least, modify subsequent attacks.

The Antigens are prepared by The Mulford Colloid Labs., and furnished in packages containing 2 one cc. Syringes with 2 sterile needles and in packages containing 4 one cc. Ampul-vials.

Literature will be mailed on request by The National Drug Co., of Philadelphia.

Present Status of Mead Johnson Vitamin A Research Award

This award was originally established by Mead Johnson & Company January 30, 1932. "Mead Johnson & Company announces an award of $15,000 to be given to the investigator or group of investigators producing the most conclusive research on the vitamin A requirements of human beings." (See J.A.M.A., January 30, 1932, pages 14-15.)

On February 11, 1933 (J.A.M.A., pages 12-13), "At the suggestion of the judges, a second (additional) award of $5,000 is now offered. The basis for this enlargement is in the obvious possibility that within the time limit set (Dec. 31, 1934), no suitable evaluation of the vitamin A

requirements of human beings will have appeared. On the other hand, a laboratory investigation may have been published which will point the way toward clinical evaluation."

On that date, the judges for the award were announced:

Issac A. Abt, Northwestern University; K. D. Blackfan, Harvard University; Alan Brown, University of Toronto; Horton R. Casparis, Vanderbilt University; H. F. Holmholz, Mayo Clinic; Alfred F. Hess, Columbia University; E. V. McCollum, Johns Hopkins University; L. B. Mendel, Yale University; L. T. Royster, University of Virginia; and Robert A. Strong, Tulane University.

The judges met in Detroit, April 10, 1935, and took the following action:

(1) To postpone until December 31, 1936, awarding of the main (Clinical) Award.

(2) To divide the second (Laboratory) Award, one-half to Dr. S. B. Wolbach, Harvard University, for his basic work on the pathology of avitaminosis A and his investigations on the regeneration of epithelial tissue impaired by vitamin A deficiency, and the relationship of vitamin A to the integrity of the teeth; and one-half to Dr. Karl E. Mason, Vanderbilt University, for distinguishing exactly between the pathology of avitaminosis A and avitaminosis E, and for his contribution to the quantitative relationship of vitamin A deficiency to the keratinization of germinal epithelia.

Some of this original work is still in press.

Checks for $2,500 each, in accordance with the decision of the Judges, were promptly mailed by Mead Johnson & Company to Dr. S. B. Wolbach and Dr. Karl E. Mason.

New Treatise of Foods and Nutrition

A very interesting and instructive booklet on food values and nutrition has been prepared, covering particularly the newer knowledge of vitamin and mineral metabolism.

A clear-cut discussion of origin and function of all the accepted vitamins is indulged in. Charts showing the relative content of vitamins, calcium, phosphorus, and total caloric value of the most common foods are presented.

Though the booklet is small in size, it forms a very handy reference work to the busy practitioner and should be kept constantly on his desk. The book has been prepared by the R. B. Davis Company, the makers of Cocomalt, and may be secured without cost on request. Write to R. B. Davis Company, Dept. S-46, Hoboken, N. J.

Borden Abstracts

SUMMARY OF MAY ISSUE

The association of vitamin D with milk enhances the value of the antirachitic factor, as shown by the clinical test reported in Abstract No. 54, in which it is stated that a crystalline vitamin D in milk was superior to the same product in oil for the cure of infantile rickets.

Comparison of the clinical efficacy of irradiated vitamin D and vitamin D milk from cows fed on irradiated yeast showed that these two products gave similar results in the cure of rickets when 50 Steenbock units of the irradiated and 60 to 65 units of the "yeast" milk were fed to rachitic infants.

This study is outlined in Abstract No. 55, while in Abstract No. 56 there is a summary of an editorial on the general value of vitamin D milk and its proper use by practising physicians. Much attention is likewise given to vitamin D milk in the book reviewed in Abstract No. 63.

Lactose, or milk sugar, is stated in Abstract No. 57 to be more conducive to healthful growth, the development of proper body weight, and longevity than is sucrose, as shown by the experimental feeding of young animals.

Casein, the chief protein of cow's milk, acts as a deterrent on the growth of certain intestinal parasites. Milk is, therefore, a valuable factor in the treatment of these conditions, as described in Abstract No. 58.

The advantages of powdered milk for military as well as general use are set forth in Abstract No. 59.

Diagnostic methods for the detection of undulant fever are outlined in Abstract No. 60.

The 1934 Year Book of Pediatrics is reviewed in Abstract No. 61.

The second edition of a standard book on nutrition is the subject of a review in Abstract No. 62, while the Proceedings of the last annual meetings of the New York and Pennsylvania Associations of Dairy and Milk Inspectors are reviewed in Abstracts Nos. 64 and 63, respectively.

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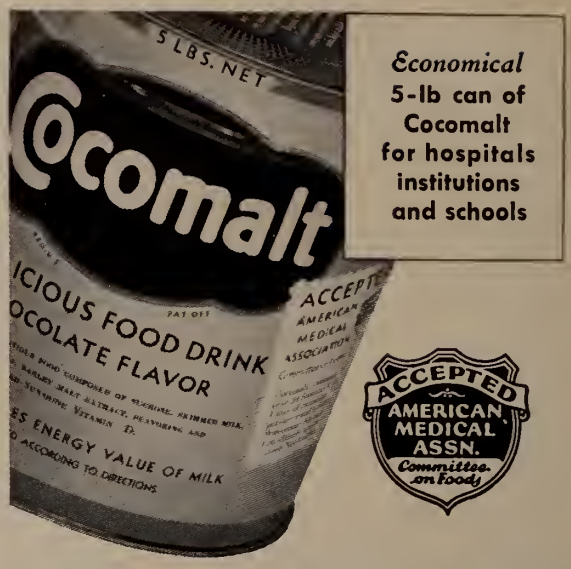
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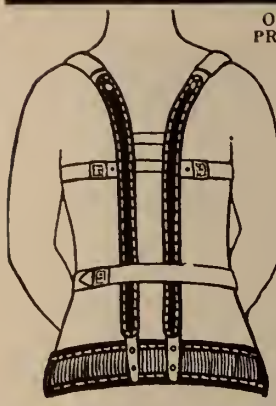
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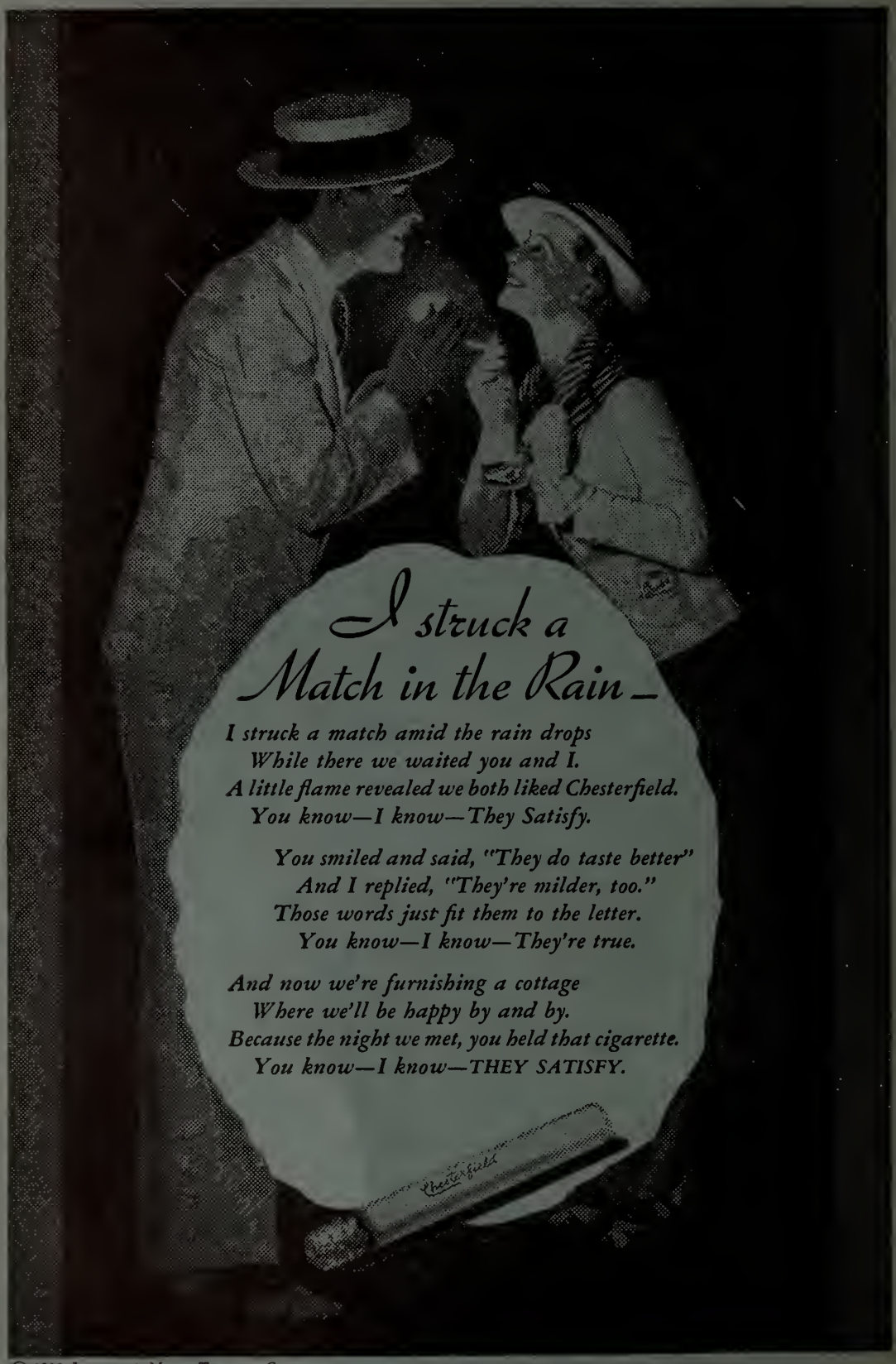
ATLANTA, GA.

Approved by the Council on Medical Education and Hospitals of the American Medical Association.

SCHEDULE OF MEETINGS—COMPONENT SOCIETIES FLORIDA MEDICAL ASSOCIATION

COUNTY SOCIETY	SECRETARY	MEETINGS				Dues Paid.
		Date	Time	Place	Luncheon?	
Alachua	Harry M. Merchant, M.D., Gainesville.	2nd Tuesday	12:00 Noon	White House Gainesville	Yes.	92%
Bay	Allen H. Miller, M.D., Millville.					80%
Brevard	Bob Schlernitzauer, M.D., Rockledge.	2nd Tuesday		Varies	Yes.	77%
Broward	Robert E. Blount, M.D., Ft. Lauderdale.	Last Wednesday.	8:00 P.M.	Elks' Hall Ft. Lauderdale	No.	95%
Columbia	T. H. Bates, M.D., Lake City.	1st Monday	7:30 P.M.	Blanche Hotel Lake City		100%
Dade	Robert T. Spicer, M.D., Miami.	1st Friday	8:30 P.M.	Club Room Huntington Bldg. Miami	Occasionally.	98%
DeSoto-Hardee-Highlands	L. W. Martin, M.D., Sebring.	2nd Tuesday	8:00 P.M.	Varies	Yes.	100%
Duval	Charles B. Mabry, M.D., Jacksonville.	1st Tuesday	8:15 P.M.	Mayflower Hotel Jacksonville	No.	63%
Escambia	J. M. Hoffman, M.D., Pensacola.	2nd Tuesday	8:00 P.M.	Board of Health Building Pensacola	No.	55%
Hillsboro	John S. Helms, Jr., M.D., Tampa.	1st Tuesday	8:00 P.M.	Tampa Municipal Hospital Tampa	No.	91%
Jackson	Lewis Pierce, M.D., Marianna.	2nd Tuesday	7:30 P.M.	Hotel Chipola, Marianna	Yes.	83%
Lake	W. L. Ashton, M.D., Umatilla.	1st Thursday	12:30 P.M.	Eustis	Yes.	95%
Lee	H. Quillian Jones, M.D., Ft. Myers.	3rd Friday	7:30 P.M.	Lee Memorial Hospital Ft. Myers	No.	100%
Leon-Gadsden-Liberty-Wakulla-Jefferson	O. G. Kendrick, M.D., Tallahassee.	Quarterly	3:00 P.M.	Varies	Yes.	82%
Madison	Geo. O. Davis, M.D., Madison.					100%
Manatee	W. D. Sugg, M.D., Bradenton.	3rd Tuesday	7:00 P.M.	Whitfield Country Club Bradenton	Yes.	75%
Marion	Richard C. Cumming, M.D., Ocala.	3rd Thursday	12:30 P.M.	Marion Hotel Ocala	Yes.	100%
Monroe	W. R. Warren, M.D., Key West.	1st Sunday	9:00 P.M.	Varies	Yes.	100%
Orange	John A. Pines, M.D., Orlando.	3rd Wednesday	8:30 P.M.	Varies	No.	96%
Palm Beach	Lloyd J. Netto, M.D., W. Palm Beach.	4th Monday	8:00 P.M.	Good Samaritan Hospital W. Palm Beach	No.	100%
Pasco-Hernando-Citrus	John J. Bourke, M.D., Dade City.	2nd Thursday	7:00 P.M.	Varies	Yes.	100%
Pinellas	O. O. Feaster, M.D., St. Petersburg	1st Friday	8:00 P.M.	Assembly Room, 5th floor, P. & L. Bldg St. Petersburg	No.	94%
Polk	J. R. Boulware, Jr., M.D., Lakeland.	2nd Wednesday in Feb., Apr., June, Aug., Oct., Dec.	1:00 P.M.	Lakeland	Yes.	100%
Putnam	E. W. Warren, M.D., Palatka.	2nd Thursday	7:00 P.M.	James Hotel, Palatka	Yes.	86%
St. Johns	John L. Bennett, M.D., St. Augustine.	3rd Tuesday	8:30 P.M.	Varies	Yes.	100%
St. Lucie-Okeechobee-Indian River-Martin	E. B. Hardee, M.D., Vero Beach.	3rd Thursday	8:00 P.M.	Varies	Yes.	71%
Sarasota	J. E. Harris, M.D., Sarasota.	2nd Tuesday	8:30 P.M.	Varies	Occasionally.	93%
Seminole	J. T. Denton, M.D., Sanford.	2nd Monday	7:00 P.M.	City Hospital Sanford	Yes.	100%
Sumter	W. E. Mitchell, M.D., Coleman.	2nd Tuesday		Varies	No.	100%
Taylor	C. A. O'Quinn, M.D., Perry.	Last Friday	8:00 P.M.	Dixie-Taylor Hotel Perry	Yes.	100%
Volusia	Hugh West, M. D., DeLand	2nd Tuesday	7:30 P.M.	Varies	Yes.	87%
Walton-Okaloosa	A. G. Williams, M.D., Lakewood.	3rd Thursday	8:00 P.M.	Varies	Occasionally.	100%

NOTE—Secretaries: Please submit information to complete the above schedule.



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